Journal of the Child Welfare League of America Inc.



# child welfare



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# CHILD WELFARE

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CHILD WELFARE is a forum for discussion in print of child welfare problems and the programs and skills needed to solve them. Endorsement does not necessarily go with the printing of opinions expressed over a signature.


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# EMOTIONAL TRANSACTIONS IN THE PREADOPTIVE STUDY*

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***The successful adoptive home study requires emotional interaction between the adoptive applicants and the caseworker. The recognition, exploration, and use of these feelings are a central part of the study.***

COUPLES who make application for adoptive placement have usually been through considerable emotional struggle before they present themselves and their plea at an adoption agency. They have primarily experienced frustration in the biologic production of their own children and this area is one which is unconsciously loaded with anxiety based in the personal Oedipal conflicts of each person. They have been forced to see themselves as different from and, therefore, less good than their childbearing friends and relatives and less good than their own parents who conceived and bore them. They frequently have been exposed to criticism by others who, ambivalent about their own parental status, take the position that the childless couple is voluntarily shirking adult responsibility. They have usually been subjected to medical studies which are embarrassing and frequently painful. Lastly, it must still be recognized that application for adoptive placement is an overt admission of biologic failure. Moreover, the idea of approaching an unknown, faceless, and impersonal agency to ask for something is, in itself, anxiety-producing. One reads in case reports that the applicants at the initial interview were tense, anxious, defensive, and somewhat hostile or that they seemed reticent, depressed, cautious, tentative, and anxious to please. Taking an empathic view of the stresses I have been describing, can anyone expect them to be anything else?

### *Stress on the Interviewer*

The interviewer at the adoptive agency, on the other hand, has his own particular kind of stress. Anyone engaged professionally in the investigation of the emotional status of others must have taken a lively interest in his own emotional status at some time or other. The usual course for this interest is personal emotional pain. From this introspective experience, and bolstered by special training, the caseworker achieves an awareness of his own inner conflicts which are being sublimated into this altruistic line of endeavor. The recognition of these conflicts in himself enables the caseworker to approach the applicant in a sympathetic and empathic manner of partial identification. However, the interviewer must be able to extrapolate from this subjective empathic experience and from the external realities of the interview and arrive at a considered judgment aimed at placing adoptive children in the best homes available.

Any intelligent and sensitive caseworker must recognize the narrowness of the path he must walk toward this judgment. At the same time he must feel not only the freedom but the necessity to scrutinize continuously the landscape of his own emotions and the emotions of the applicants. Just as the applicants bring anxiety to the interview and would be less than satisfactorily human if they did not, so the worker brings anxiety to the interview and would be less than satisfactorily sensitive and conscientious if he did not. He must reach a decision involving the life-long situational and emotional status of a homeless child and a childless home.

And so the applicants stand at one end of the obstacle course of understanding and agreement and the interviewer stands at the other. They must work toward each other over the obstacles, painfully carrying their ever-changing burdens of prejudice and anxiety. It is to be hoped that the burdens may be gradually lightened as mutual progress is made. However, it is a mutual effort and involves some loss of "status quo" comfort on both sides.

* Based on a talk given to the Minnesota Council on Adoptions at the Minnesota State Welfare Conference, St. Paul, March 22, 1961.

### *The Preadoptive Interview*

Verbal communication through the medium of language and speech is a feeble tool but is the best we have. It is because of this and because of the present-day realization that it is most important to understand both the conscious and unconscious processes of applicants that decisions are made by way of vis-a-vis interview rather than by questionnaire. The framework of the interview generally should be in terms of data that would be obtained from a questionnaire aimed at discovering the presence or absence of serious emotional or physical disease both in the past and in the current situation. Many excellent outlines for history-taking can be found in reputable textbooks of psychiatry or of case study technic. An important factor is that no textbook can tell anybody the best or surest way to adduce the material called for in the outlines. There are, however, general broad principles which can make the interview an easier and less frustrating situation for all protagonists.

The interviewer must remember and respect the fact that the applicants are experiencing anxiety for the reasons previously described. The applicants are also likely to be trying to cover up this anxiety in the mistaken impression that if the anxiety is noticed they will be adjudged to be neurotic and, therefore, will be rejected as unfit. As previously mentioned, the interviewer is probably experiencing some anxiety, too. He should be aware of this, admit the fact to himself, and then try to use his own anxiety to help him understand that of the applicants. The interviewer's anxiety all too frequently causes him to retreat into a cold professionalism as a reaction-formation or to rush forward into overdetermined identification with the applicants in which sound judgment and objectivity are lost.

Probably the most effective way to dissipate the more irrational parts of the bilateral anxiety is for the interviewer to say to the applicants that he knows that this is a difficult and frightening experience and that anxiety is usually felt. Most often, this empathic communication sets the applicants more at ease; it tells them that they are to be treated as humans by a human, and it lessens their defensiveness. This lessening of their defensiveness should put the interviewer more at ease. Sometimes, however, this introductory bit will seem to produce either no change at all or a seemingly paradoxical increase in defensiveness. If this occurs, the interviewer finds himself already involved in the business of investigating the cause and depth of the defensive attitude. It is best at this point to make some comment on the apparent increase in the tension and to ask why. It is chiefly important that the interviewer imply in the question that he really wants to know so that he may be of help. The answer is likely to lead directly into background history. Whether the interviewer likes it or not, he is involved in a transference situation the moment he meets these applicants.

The recognition of this transference situation can lead to the most sensitive insights into the applicants' attitudes toward dependency and aggression and, in a general way, to some understanding of what the applicant has learned to expect from authority. In the later interviews these insights can help predict what kind of authority the applicants will bring to their own positions as parents.

It is proper for the interviewer to have a specific outline in mind and to check off mentally the various items as they are covered. But to proceed in a slavish adherence to a set sequence inevitably leads to the collection of much data but little information. Questions put in a predetermined, rigid sequence can elicit only brief and relatively noncommittal answers. The individual's emotional structure guides the seemingly spontaneous sequence of a thought-train. Thus, if the interviewer is guided by his own associations as to what the applicant has just said, he arrives at the next best question by a process of emotional connection. It is likely that the applicant is equally ready to deal with the next question in a way which is emotionally revealing because of similar associations in himself. Now the answer becomes meaningful not only as an isolated entity but as a significant link with what has preceded and what is to follow. Often these important linkages are not verbalized but are empathically understood by both parties. Such nonverbal communications commonly increase the ease and understanding much more than any formal reassurance.

Sometimes, after initial introductions and the establishment of some modicum of mutual

ease, an applicant can be started off, as it were, by general and very broad questions. Once started, some applicants may go on spontaneously to tell a great deal about themselves with little urging or guiding. If the production seems to be essentially a rather three-dimensional one with elements of happiness and unhappiness, pleasure and pain, and in general, all or most of the elements of human existence displayed with appropriate emotional coloration, then it is likely that the applicant is not only honest and capable of self-scrutiny but is also probably a rather well-adjusted person. At least the applicant is able to remember and communicate his memories with minimal fear that these will materially contaminate the present or the future.

I do not think it possible to outline briefly, clearly, and succinctly how to reach an intelligent decision as to the emotional suitability of applicants for adoption. It seems relatively easy to rule out applicants when major and crippling emotional problems are discovered. The major problem is ruling applicants *in,* since any thorough and sensitive study is going to reveal areas of conflict and even areas of neurosis in any person so studied. The real task is evaluating whether these interfere with the applicants' life to such degree that there might be serious limitation of the capacity to love, respect, and care for an adopted child. The most revealing material in the whole study may derive less from past anxieties and traumas than from the present-day adjustment of the applicant. Part of the present-day situation is the frustration and disappointment of a childless marriage. It is important to find out just how the couple has dealt with this frustration up to the point of adoptive application. What led them to make the decision to apply? Have they really talked it over with each other and faced the anxiety attendant on working through to a decision? With whom else have they discussed this? Why did they select this particular person to talk to? Lastly, why do the applicants wish to have children? All of these questions can tap areas of current emotional adjustment in the marriage, the relationship of the individuals to each other, and the relationship of the couple to others.

In the area of specific attitudes toward parenthood and the child there are numerous other questions of considerable value and sensitivity. Most of these can be well handled by asking the couple to fantasize what it might be like to have an adopted child or to be an adopted child. What ideas do they have about the biologic parents of this potential child they may take as their own? How do they feel about the problem of telling a child he is adopted? When do they think the child should be told? How will they handle the questions the child will ask about procreation in general and about his own origins specifically? What might they do or say in response to a possible situation in which the child says he doesn't have to obey them "because you are not my real parents"? What do they want their adopted child to be like, meaning what age, what sex, and what physical appearance, and why are these factors considered to be important?

All of these are difficult questions because they touch on the anxieties and fears common to all. These questions touch through defenses and invite the couple to deal with their anxieties in a relatively safe situation. It is important that this type of question be used not only for the collection of personality information for the interviewer, but, in addition, because this painful experience serves as a rehearsal or immunization against seriously limiting anxiety which might arise during the actual rearing of the child if consideration of these problems were postponed until a reality situation brought the anxiety to crisis. Reviewing these possibilities in the presence of an authority on adoption problems reassures the prospective parents and gives them a basis for confident handling of the situations that may arise in reality. The very fact that the questions are put to them tells the prospective parents that their own doubts, fears and misgivings are not unique. However, there is still another excellent reason why the preadoptive study produces anxiety, why there must be anxiety, and why this anxiety has actual emotional value for the couple.

### *The Value of Preadoptive Anxiety to the Applicants*

It may seem strange to speak of the value or worth of something as painful and disagreeable as anxiety. However, any major change in the life of any individual is normally accom-

panied by some anxiety and some depression. This is not only because of the common fear of the unknown future brought forward by the risk and gamble of a change but also because each change involves not only the acquisition of something new but the relinquishment of something old. If the anxiety can be faced and recognized and if some mourning for what has been given up can take place before and during the change, then the chances are good that these affects need not arise in serious degree to contaminate later adjustment to the new environment. Every new thing is paid for with anxiety, and in this analogy cash-on-the-line payment is more effective than long-delayed installments or a prolonged debt.

Let us now imagine a couple about to be accepted for adoptive parenthood. If they had been able to conceive and bear their own child, they would have had a nine-month period of preparation. During this time they would have been gradually shifting some of their feelings around in anticipation of the arrival of the baby. Assuming that they are emotionally healthy, they would have spent some time joyfully looking forward, fantasizing what the baby would be like, how they would care for it, and what responsibilities each would take toward the baby and toward each other. This is at the same time an anticipatory excursion into the future by the route of fantasy and also a relinquishment of some of the elements of their past lives. In this there are mingled elements of pleasure and pain, joy and sadness, anticipation and mourning. The couple would talk together, share their joy and their fears and apprehensions, giving each other reciprocal support, reassurance, and comfort. Through this, the child's presence becomes ever more real, and in the healthy situation the child is there and a part of the family actually before delivery.

Adoptive parents miss all of this. The adoptive couple have no gestation period except for the small model of pregnancy that is emotionally furnished in the preadoptive study. The anxiety experienced in the study, and its gradual alleviation, is the best opportunity that the adoptive couple have to experience an emotional analogue of the nine-month period of preparation of a biologic pregnancy. Even if a brief, casual, and anxiety-free placement study could be devised, I am of the opinion that it would deprive the adoptive parents of a valuable time of preparation. Preparation for any major change is poignant and painful but necessary if the actual change is to be followed by reasonable and relative freedom from anxiety and doubt.

Even with the best preadoptive interview and counselling procedure this analogue of gestation cannot be expected to approach biologic pregnancy in thoroughness, intensity, and immediacy of feeling. The physical sensations of the pregnancy are absent. The infant is not inside the adoptive mother to be felt moving and growing. Usually there has been some secrecy about the application for adoption; thus many friends and acquaintances do not know about the approaching new parenthood and cannot find out through direct observation of some change in the adoptive mother's figure. There is thus less communication with others about the prospective change in the family structure. In many ways the baby remains as emotionally anonymous as it is physically unknown. In such a situation there still remain large areas of uneasy unreadiness.

When the parents are told that they are accepted for adoptive placement, they are glad, reassured about themselves, and, at first, overjoyed. But then they may begin to notice that they are not as thrilled as they expected to be. They begin to find more and more areas of doubt. They may feel vaguely guilty because they recognize some selfish qualms at having to give up certain of their childless comforts for a child of whom they have no real knowledge or experience. An objective and dispassionate but psychologically informed look at this situation tells us that this is a rather natural state of affairs. Can any couple be expected to look forward without considerable ambivalence to the intense and life-long intrusion into their privacy by a completely anonymous person? If the caseworker understands this, anticipates the letdown, and does what is necessary to dispel the guilt about ambivalence, the couple can come to the moment of placement with much more comfort. They can realize that it is not necessary to love this stranger wholeheartedly while it is still a stranger. They can recognize that they want to love and that love can come

but that it comes only with proximity and experience. Trusting in their own capacities for love, they can look forward to the experience with an expectful confidence not contaminated with guilty urgency.

### *The Value of the Anxiety to the Interviewer*

As the working through of the anxiety attendant on the preadoptive study is an important maturing factor for the parents so also is this of emotional importance to the caseworker. He acquires a better understanding of himself through the acknowledgment and inspection of emotional areas of the study that have cost him anxiety. Through learning not to avoid anxiety, he acquires confidence in his own sensitivity and integrity and comes to find that the occurrence of anxiety in himself may be something more than a danger signal. It also may be an important signpost pointing at new areas of information and understanding. The memory of the anxiety is an assurance that the task has been performed with conscientiousness and integrity.

At the termination of each case the worker may feel some sadness and perhaps some apprehension mixed with the pleasure and gratification. This is because the caseworker, too, is giving up something. He has allowed himself to participate emotionally with the actual mother of the child, with the child itself, and with the adoptive parents. He has performed his function so well that now all of those persons have no further need of him and are functioning independently of him. He is mostly happy and proud about this but he is losing a relationship that has fulfilled some of his own need to be needed.

### *Summary*

The successful preadoptive study culminating in placement is an emotional interaction between human beings endowed with feelings. The recognition, exploration, and use of these feelings are a central part of the study. The emotional evaluation must take into consideration not merely the past history of the applicants but also the current and ongoing affective experience of the study with its transference and counter-transference reverberations in the persons of all the protagonists. The caseworker's feelings are a quintessential part of this interplay. In this way the worker can be assured not only of more sensitive data available for decision but also can be of invaluable assistance in the emotional preparation of the applicants for parenthood. For the caseworker there is professional satisfaction, but deeper than this is the gratification of having been privileged to see another as a total human being. Through this the caseworker recognizes his own totality and this brings him closer to the real and future acceptance of others through acceptance of the self. He looks forward to the next case with less defensiveness and more humble self-confidence.

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## Director of Development Appointed by League

The League is pleased to announce the appointment of Mr. Aaron Cecil Sterling as Director of Development.

Mr. Sterling came to the League staff from the Eleanor Roosevelt Cancer Foundation, where he was Associate Eastern Regional Director. He has had experience in community organization, in Community Chest and Council work, and as a newspaper feature writer.

He is a graduate of New York University and holds a master's degree from the New York School of Social Work, Columbia University.

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## A Special for Students

Students may now receive their personal copies of CHILD WELFARE and not have to be dependent upon the school library copy! Subscription rates for students enrolled in a school have been greatly reduced to assist students in being informed about the child welfare field.

The annual subscription rate has been reduced to $2.00; the two-year rate is now only $3.50. Twenty or more students may subscribe and have copies mailed to their school for distribution at a yearly rate of $1.75 for each subscription.

# DETERRENTS TO EARLY PRENATAL CARE AND SOCIAL SERVICES AMONG UNWED MOTHERS*

*Blanche Bernstein*
**Consultant**

**Formerly Director of Research**
**Community Council of Greater New York**
**New York, N. Y.**

***The major findings and conclusions of a research study.***

HEALTH and welfare authorities in New York City and New York State have been concerned over the high prenatal mortality rate which prevails among out-of-wedlock children as compared to children born in wedlock, and also over both the health and the welfare of the unmarried mother and her child. The study reported on here stemmed from that concern.[1] I must stress that it is *not* a study of the reasons for the rising trend in illegitimacy or of means to reverse this trend. Rather it was designed to determine the deterrents to care in order to provide the basis for community efforts to overcome the obstacles to social services and early prenatal care for these women. Its object was to determine the extent to which unmarried mothers seek and obtain prenatal care and social services during pregnancy; the reasons they do not obtain *early* care and social services, if they obtain any; and the socio-economic characteristics of the women who delay seeking care, if they seek it at all.

Information was obtained on the history of the entire pregnancy directly from a representative group of 520 unmarried mothers, in the course of face-to-face interviews with them in the hospital shortly after they were confined. The selection of hospitals was based in general on a stratified probability sample of all hospitals in the city, excluding proprietary hospitals, hospitals in which relatively few unmarried mothers are confined, and one large municipal hospital, which was excluded for administrative reasons.

The technique for the selection of hospitals, the low rate of refusals, and the high rate of identification of unmarried mothers by the hospital staffs produced a reasonably unbiased sample of unmarried mothers in this city. Some slight bias may have been introduced by excluding the small group of women confined in proprietary hospitals, which generally serve a relatively high socio-economic group. All the checks which could be made, however, indicate that such under-representation is slight.

In this summary of a fairly lengthy study, I have selected certain highlights which are particularly significant in terms of developing community programs for overcoming the obstacles to early prenatal care and social services.

## *Socio-economic Characteristics of Unmarried Mothers*

Before the socio-economic characteristics of unmarried mothers are described, it must be stated that data on such characteristics as age or ethnic or religious group are important not because of any causal relationship between them and out-of-wedlock pregnancy, but so that groups in need of the community's special attention can be identified and reached, and so that any differences in patterns of behavior in relation to the problems under study can be taken into account in developing community programs.

Unmarried mothers include a wide range of women. The youngest in the study was thirteen years of age and the oldest, forty-seven. All major ethnic groups in the city were represented. About half of these women were bearing their first out-of-wedlock child; a few,

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* Given at the CWLA Eastern Regional Conference, New York City, on April 21, 1961.

[1] This study was conducted by the Community Council of Greater New York, in co-operation with the New York State Department of Social Welfare and the U. S. Children's Bureau, with the use of Federal Child Welfare Services funds. For more detailed information on the results of the study, see Blanche Bernstein and Mignon Sauber, *Deterrents to Early Prenatal Care and Social Services among Women Pregnant Out-of-Wedlock*, New York State Department of Social Welfare, Albany, N. Y., 1961.

their tenth. But although unmarried mothers do come from a wide range of age, ethnic and socio-economic groups, they are found more frequently in some groups than in others.

Over 60 percent of the unwed mothers in New York City are Negro, 18 percent are white, and nearly 20 percent are Puerto Rican. In terms of rates of illegitimacy, among white women about two out of every hundred births are out of wedlock, among Negro women the rate is about twenty-five out of every hundred, and among Puerto Rican women, eleven out of every hundred. Since this and many other studies indicate that out-of-wedlock births are heavily concentrated among lower income groups, it is not surprising to find that rates of illegitimacy are higher among the Negro and Puerto Rican women than among the white women.

In any one year, 8 percent of unmarried mothers are under seventeen years of age; another 23 percent are over seventeen but less than twenty. Many are mature women, however: at least 37 percent are twenty-five or older. It is significant that although in any one year only 8 percent of unmarried mothers are under seventeen, about 18 percent were under seventeen when they had their *first* out-of-wedlock child, and altogether almost 50 percent were less than twenty years old when the first out-of-wedlock child was born.

For over half the unmarried mothers in the study the current child is the first born out of wedlock; for about a quarter it is the second. About a quarter of the unwed mothers have at least two other out-of-wedlock children besides the current one, including about 13 percent who have at least three. Among whites, 86 percent are having the first illegitimate child; among Negroes, only 45 percent are having the first one.

A fourth of the women bearing children out of wedlock had previously been married and are now separated, divorced or widowed, or deserted by their husbands. The remaining three-quarters are single.

Only about a fourth of the women currently bearing children out of wedlock in New York City were born here, and only about a third spent most of their childhood here. Over two-thirds of the Negro women were born in the South and about 60 percent of them grew up there; substantially all of the Puerto Rican unmarried mothers were born in Puerto Rico and most of them grew up there. Thus it is evident that the rate of illegitimacy is much higher among groups born and raised in a relatively nonurban, nonindustrial environment in which the legal aspects of family life are not always considered as important as in a more urbanized society. Over 80 percent, however, have been living in New York City for at least three years. The overwhelming majority, therefore, are residents of New York City, not women who come here solely to have the illegitimate child.

Many unwed mothers are themselves the products of broken homes; only about half in this study lived with both parents throughout their childhood. Among whites, however, 76 percent grew up in intact families, while among Negroes and Puerto Ricans, 40 to 50 percent did so.

It is evident that the educational attainment of these unwed mothers is not up to the prevailing level for females in the community. For example, in the twenty- to twenty-four-year-old group, which can be assumed to have completed its schooling, 20 percent have not gone beyond grade school, compared to only 14 percent in the total female population. Only about 6 percent of unwed mothers have some college education compared to 22 percent in the total population. It cannot be said, however, that unwed mothers constitute an uneducated group, since over 60 percent reach at least the high school level, including roughly 6 percent with some college training.

### *Patterns of Prenatal Medical Care*

Unmarried mothers do, indeed, delay seeking medical care longer than do married mothers. As many as 17 percent do not obtain any prenatal care; among married mothers less than 3 percent obtain no prenatal care. At the other end of the scale, only 26 percent of unwed mothers obtain prenatal care in the first trimester in comparison with 40 percent of married mothers. The very young, those under 17 years, delay seeking care more than other age groups; only 7 percent seek care in the first trimester and obtain it regularly thereafter. The Puerto Ricans delay more than other ethnic groups, but differences among ethnic groups are not enormous. Level of education and employment during preg-

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### *The Value of Preadoptive Anxiety to the Applicants*

It may seem strange to speak of the value or worth of something as painful and disagreeable as anxiety. However, any major change in the life of any individual is normally accom-

panied by some anxiety and some depression. This is not only because of the common fear of the unknown future brought forward by the risk and gamble of a change but also because each change involves not only the acquisition of something new but the relinquishment of something old. If the anxiety can be faced and recognized and if some mourning for what has been given up can take place before and during the change, then the chances are good that these affects need not arise in serious degree to contaminate later adjustment to the new environment. Every new thing is paid for with anxiety, and in this analogy cash-on-the-line payment is more effective than long-delayed installments or a prolonged debt.

Let us now imagine a couple about to be accepted for adoptive parenthood. If they had been able to conceive and bear their own child, they would have had a nine-month period of preparation. During this time they would have been gradually shifting some of their feelings around in anticipation of the arrival of the baby. Assuming that they are emotionally healthy, they would have spent some time joyfully looking forward, fantasizing what the baby would be like, how they would care for it, and what responsibilities each would take toward the baby and toward each other. This is at the same time an anticipatory excursion into the future by the route of fantasy and also a relinquishment of some of the elements of their past lives. In this there are mingled elements of pleasure and pain, joy and sadness, anticipation and mourning. The couple would talk together, share their joy and their fears and apprehensions, giving each other reciprocal support, reassurance, and comfort. Through this, the child's presence becomes ever more real, and in the healthy situation the child is there and a part of the family actually before delivery.

Adoptive parents miss all of this. The adoptive couple have no gestation period except for the small model of pregnancy that is emotionally furnished in the preadoptive study. The anxiety experienced in the study, and its gradual alleviation, is the best opportunity that the adoptive couple have to experience an emotional analogue of the nine-month period of preparation of a biologic pregnancy. Even if a brief, casual, and anxiety-free placement study could be devised, I am of the opinion that it would deprive the adoptive parents of a valuable time of preparation. Preparation for any major change is poignant and painful but necessary if the actual change is to be followed by reasonable and relative freedom from anxiety and doubt.

Even with the best preadoptive interview and counselling procedure this analogue of gestation cannot be expected to approach biologic pregnancy in thoroughness, intensity and immediacy of feeling. The physical sensations of the pregnancy are absent. The infant is not inside the adoptive mother to be felt moving and growing. Usually there has been some secrecy about the application for adoption; thus many friends and acquaintances do not know about the approaching new parenthood and cannot find out through direct observation of some change in the adoptive mother's figure. There is thus less communication with others about the prospective change in the family structure. In many ways the baby remains as emotionally anonymous as it is physically unknown. In such a situation there still remain large areas of uneasy unreadiness.

When the parents are told that they are accepted for adoptive placement, they are glad, reassured about themselves, and, at first, overjoyed. But then they may begin to notice that they are not as thrilled as they expected to be. They begin to find more and more areas of doubt. They may feel vaguely guilty because they recognize some selfish qualms at having to give up certain of their childless comforts for a child of whom they have no real knowledge or experience. An objective and dispassionate but psychologically informed look at this situation tells us that this is a rather natural state of affairs. Can any couple be expected to look forward without considerable ambivalence to the intense and life-long intrusion into their privacy by a completely anonymous person? If the caseworker understands this, anticipates the letdown, and does what is necessary to dispel the guilt about ambivalence, the couple can come to the moment of placement with much more comfort. They can realize that it is not necessary to love this stranger wholeheartedly while it is still a stranger. They can recognize that they want to love and that love can come

but that it comes only with proximity and experience. Trusting in their own capacities for love, they can look forward to the experience with an expectful confidence not contaminated with guilty urgency.

### *The Value of the Anxiety to the Interviewer*

As the working through of the anxiety attendant on the preadoptive study is an important maturing factor for the parents so also is this of emotional importance to the caseworker. He acquires a better understanding of himself through the acknowledgment and inspection of emotional areas of the study that have cost him anxiety. Through learning not to avoid anxiety, he acquires confidence in his own sensitivity and integrity and comes to find that the occurrence of anxiety in himself may be something more than a danger signal. It also may be an important signpost pointing at new areas of information and understanding. The memory of the anxiety is an assurance that the task has been performed with conscientiousness and integrity.

At the termination of each case the worker may feel some sadness and perhaps some apprehension mixed with the pleasure and gratification. This is because the caseworker, too, is giving up something. He has allowed himself to participate emotionally with the actual mother of the child, with the child itself, and with the adoptive parents. He has performed his function so well that now all of those persons have no further need of him and are functioning independently of him. He is mostly happy and proud about this but he is losing a relationship that has fulfilled some of his own need to be needed.

### *Summary*

The successful preadoptive study culminating in placement is an emotional interaction between human beings endowed with feelings. The recognition, exploration, and use of these feelings are a central part of the study. The emotional evaluation must take into consideration not merely the past history of the applicants but also the current and ongoing affective experience of the study with its transference and counter-transference reverberations in the persons of all the protagonists. The caseworker's feelings are a quintessential part of this interplay. In this way the worker can be assured not only of more sensitive data available for decision but also can be of invaluable assistance in the emotional preparation of the applicants for parenthood. For the caseworker there is professional satisfaction, but deeper than this is the gratification of having been privileged to see another as a total human being. Through this the caseworker recognizes his own totality and this brings him closer to the real and future acceptance of others through acceptance of the self. He looks forward to the next case with less defensiveness and more humble self-confidence.

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## Director of Development Appointed by League

The League is pleased to announce the appointment of Mr. Aaron Cecil Sterling as Director of Development.

Mr. Sterling came to the League staff from the Eleanor Roosevelt Cancer Foundation, where he was Associate Eastern Regional Director. He has had experience in community organization, in Community Chest and Council work, and as a newspaper feature writer.

He is a graduate of New York University and holds a master's degree from the New York School of Social Work, Columbia University.

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## A Special for Students

Students may now receive their personal copies of CHILD WELFARE and not have to be dependent upon the school library copy! Subscription rates for students enrolled in a school have been greatly reduced to assist students in being informed about the child welfare field.

The annual subscription rate has been reduced to $2.00; the two-year rate is now only $3.50. Twenty or more students may subscribe and have copies mailed to their school for distribution at a yearly rate of $1.75 for each subscription.

# DETERRENTS TO EARLY PRENATAL CARE AND SOCIAL SERVICES AMONG UNWED MOTHERS*

*Blanche Bernstein*
**Consultant**

**Formerly Director of Research**
**Community Council of Greater New York**
**New York, N. Y.**

***The major findings and conclusions of a research study.***

HEALTH and welfare authorities in New York City and New York State have been concerned over the high prenatal mortality rate which prevails among out-of-wedlock children as compared to children born in wedlock, and also over both the health and the welfare of the unmarried mother and her child. The study reported on here stemmed from that concern.[1] I must stress that it is *not* a study of the reasons for the rising trend in illegitimacy or of means to reverse this trend. Rather it was designed to determine the deterrents to care in order to provide the basis for community efforts to overcome the obstacles to social services and early prenatal care for these women. Its object was to determine the extent to which unmarried mothers seek and obtain prenatal care and social services during pregnancy; the reasons they do not obtain *early* care and social services, if they obtain any; and the socio-economic characteristics of the women who delay seeking care, if they seek it at all.

Information was obtained on the history of the entire pregnancy directly from a representative group of 520 unmarried mothers, in the course of face-to-face interviews with them in the hospital shortly after they were confined. The selection of hospitals was based in general on a stratified probability sample of all hospitals in the city, excluding proprietary hospitals, hospitals in which relatively few unmarried mothers are confined, and one large municipal hospital, which was excluded for administrative reasons.

The technique for the selection of hospitals, the low rate of refusals, and the high rate of identification of unmarried mothers by the hospital staffs produced a reasonably unbiased sample of unmarried mothers in this city. Some slight bias may have been introduced by excluding the small group of women confined in proprietary hospitals, which generally serve a relatively high socio-economic group. All the checks which could be made, however, indicate that such under-representation is slight.

In this summary of a fairly lengthy study, I have selected certain highlights which are particularly significant in terms of developing community programs for overcoming the obstacles to early prenatal care and social services.

## *Socio-economic Characteristics of Unmarried Mothers*

Before the socio-economic characteristics of unmarried mothers are described, it must be stated that data on such characteristics as age or ethnic or religious group are important not because of any causal relationship between them and out-of-wedlock pregnancy, but so that groups in need of the community's special attention can be identified and reached, and so that any differences in patterns of behavior in relation to the problems under study can be taken into account in developing community programs.

Unmarried mothers include a wide range of women. The youngest in the study was thirteen years of age and the oldest, forty-seven. All major ethnic groups in the city were represented. About half of these women were bearing their first out-of-wedlock child; a few

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* Given at the CWLA Eastern Regional Conference, New York City, on April 21, 1961.

[1] This study was conducted by the Community Council of Greater New York, in co-operation with the New York State Department of Social Welfare and the U. S. Children's Bureau, with the use of Federal Child Welfare Services funds. For more detailed information on the results of the study, see Blanche Bernstein and Mignon Sauber, *Deterrents to Early Prenatal Care and Social Services among Women Pregnant Out-of-Wedlock*, New York State Department of Social Welfare, Albany, N. Y., 1961.

their tenth. But although unmarried mothers do come from a wide range of age, ethnic and socio-economic groups, they are found more frequently in some groups than in others.

Over 60 percent of the unwed mothers in New York City are Negro, 18 percent are white, and nearly 20 percent are Puerto Rican. In terms of rates of illegitimacy, among white women about two out of every hundred births are out of wedlock, among Negro women the rate is about twenty-five out of every hundred, and among Puerto Rican women, eleven out of every hundred. Since this and many other studies indicate that out-of-wedlock births are heavily concentrated among lower income groups, it is not surprising to find that rates of illegitimacy are higher among the Negro and Puerto Rican women than among the white women.

In any one year, 8 percent of unmarried mothers are under seventeen years of age; another 23 percent are over seventeen but less than twenty. Many are mature women, however: at least 37 percent are twenty-five or older. It is significant that although in any one year only 8 percent of unmarried mothers are under seventeen, about 18 percent were under seventeen when they had their *first* out-of-wedlock child, and altogether almost 50 percent were less than twenty years old when the first out-of-wedlock child was born.

For over half the unmarried mothers in the study the current child is the first born out of wedlock; for about a quarter it is the second. About a quarter of the unwed mothers have at least two other out-of-wedlock children besides the current one, including about 13 percent who have at least three. Among whites, 86 percent are having the first illegitimate child; among Negroes, only 45 percent are having the first one.

A fourth of the women bearing children out of wedlock had previously been married and are now separated, divorced or widowed, or deserted by their husbands. The remaining three-quarters are single.

Only about a fourth of the women currently bearing children out of wedlock in New York City were born here, and only about a third spent most of their childhood here. Over two-thirds of the Negro women were born in the South and about 60 percent of them grew up there; substantially all of the Puerto Rican unmarried mothers were born in Puerto Rico and most of them grew up there. Thus it is evident that the rate of illegitimacy is much higher among groups born and raised in a relatively nonurban, nonindustrial environment in which the legal aspects of family life are not always considered as important as in a more urbanized society. Over 80 percent, however, have been living in New York City for at least three years. The overwhelming majority, therefore, are residents of New York City, not women who come here solely to have the illegitimate child.

Many unwed mothers are themselves the products of broken homes; only about half in this study lived with both parents throughout their childhood. Among whites, however, 76 percent grew up in intact families, while among Negroes and Puerto Ricans, 40 to 50 percent did so.

It is evident that the educational attainment of these unwed mothers is not up to the prevailing level for females in the community. For example, in the twenty- to twenty-four-year-old group, which can be assumed to have completed its schooling, 20 percent have not gone beyond grade school, compared to only 14 percent in the total female population. Only about 6 percent of unwed mothers have some college education compared to 22 percent in the total population. It cannot be said, however, that unwed mothers constitute an uneducated group, since over 60 percent reach at least the high school level, including roughly 6 percent with some college training.

### *Patterns of Prenatal Medical Care*

Unmarried mothers do, indeed, delay seeking medical care longer than do married mothers. As many as 17 percent do not obtain any prenatal care; among married mothers less than 3 percent obtain no prenatal care. At the other end of the scale, only 26 percent of unwed mothers obtain prenatal care in the first trimester in comparison with 40 percent of married mothers. The very young, those under 17 years, delay seeking care more than other age groups; only 7 percent seek care in the first trimester and obtain it regularly thereafter. The Puerto Ricans delay more than other ethnic groups, but differences among ethnic groups are not enormous. Level of education and employment during preg-

nancy, as such, appear to have little impact on the timing of prenatal care among unwed mothers. The more important factor influencing its timing and regularity is whether the unmarried mother is bearing her first or second out-of-wedlock child or her third or fourth, etc. The data indicate a tendency to delay prenatal care during the third or fourth pregnancy, a tendency which is also apparent among married women.

Many unwed mothers obtain medical care from more than one source. The patterns by age and ethnic group vary significantly. Relatively more young teenagers and whites initially seek care from a private doctor rather than a clinic. The preponderant majority in all age and ethnic groups, however, turn finally to a clinic for prenatal care, since the private doctor is generally sought only to verify the pregnancy.

### *Patterns of Use of Social Agency Services*

Prenatal medical care is, of course, considered essential for all pregnant women whether married or not. In the main, however, it is only the *unmarried* expectant mothers who need social agency services because of the pregnancy. This need derives from society's attitudes toward illegitimacy, attitudes which reflect the views of the dominant middle-class white group. These attitudes are not all-pervasive, however, and actions which are common in a certain segment of society may have less traumatic consequences to the members of that segment than to members of the dominant white group. As indicated, in New York City about one-fourth of all births to Negro women occur out of wedlock. Such births are concentrated among the poorer, less educated, most recent migrants to the city, so that in this part of the Negro group, the rate of illegitimacy may approach as much as 50 percent. The pattern of use of social agency services by unmarried mothers can be understood only in the framework of the prevailing differences in attitudes toward illegitimacy in the various segments of the population, and to some extent the differences in cultural patterns with respect to use of social services other than financial assistance.

The most striking fact which emerges from the study is that as many as 29 percent of unmarried mothers do not have any contact with any social agency at any time during the pregnancy. Only 19 percent obtain assistance from agencies with specialized services for unwed mothers, such as shelter care, adoption services or counseling; 40 percent are in contact with hospital social service workers; 42 percent with the Bureau of Public Assistance for financial help; 12 percent with the Bureau of Child Welfare; 5 percent with the schools; 6 percent with the courts; and 7 percent with other social agencies. These figures reflect the fact that although 29 percent of all unwed mothers are not in touch with any social agency during the pregnancy, others contact two or more.

The effect of varying attitudes toward illegitimacy on the use of social agency services is shown by the differential rates of use by ethnic group. Among the white unwed mothers, about 72 percent obtain service from specialized agencies, 16 percent from other casework agencies, 2 percent exclusively from the Bureau of Public Assistance, and only 10 percent remain without any social agency service during pregnancy. Among Negro and Puerto Rican women, however, only 5 and 10 percent, respectively, obtain specialized services, and as many as a third have no social agency contacts at all.

Use of social agency services also varies greatly by age—far more than does use of medical care services. The young teenagers are again the most sharply differentiated from the other age groups. As might be expected, they constitute a disproportionately large segment of those served. About 50 percent are served by specialized agencies and only 9 percent have no contact with any social agency. Also relatively more of the unwed mothers who come to New York in order to conceal the pregnancy from family and friends in their own community seek social agency services. The higher the level of education the more likely it is that an unwed mother will seek social services. The more children she has, however, the less likely she is to do so.

Only 21 percent of unwed mothers seek help from a social agency in making a decision about their plans for the baby. The majority of white mothers expect to place the baby for adoption, while 87 percent of the Negro mothers and 94 percent of the Puerto Rican mothers plan to keep the baby.

### *Deterrents to Medical Care*

The main deterrents to prenatal medical care, in order of importance, are: the women see no need to get care earlier or at all (20 percent); they try to conceal their pregnancy as long as possible (18 percent); they find it inconvenient either because they are caring for children at home or for other reasons (16 percent); they are reluctant to give up their jobs or take time off (12 percent); they do not know they are pregnant (9 percent); they cannot pay the costs of care by a private physician (7 percent); or finally, clinic intake requirements at the clinic where service is requested make them ineligible (6 percent). Contrary to expectation, lack of knowledge about medical care facilities is not a significant deterrent to early prenatal care.

The relative importance of different deterrents varies significantly by age and ethnic group. The desire to conceal the pregnancy, ignorance of the condition, and inability to face it are the deterrents found most frequently among young teenagers and among whites. Among older unwed mothers, relatively more see no need to seek care earlier, or find it inconvenient because they are caring for children at home or because they are working. Among the Negro and Puerto Rican women, the two most common deterrents are the fact that they see no need for earlier care and that they find it inconvenient because they are caring for children at home. In addition, in the Negro group, job-related factors are an important deterrent; in the Puerto Rican group, the desire to conceal the pregnancy and fear of medical examinations are significant factors.

When medical care is refused for whatever reason, prenatal care is likely to be delayed and sometimes no further effort is made to obtain care. Clinic requirements are an important deterrent among young teenagers and among Negroes—for the former, because many clinics will not examine a minor without the parent's signed permission, and for the latter, because more Negroes happen to turn up at clinics which do not serve their district or residence.

In most cases, when an agency or professional person refers an unwed mother for prenatal care, it (or he) also makes the necessary arrangements. But often, particularly when the referral is made by a private doctor, the unwed mother is left to her own devices. Thus some are "lost" in the referral process.

Despite the fact that they are in contact with the Bureau of Public Assistance, the unwed mothers who are already on assistance have a poorer record of prenatal care than either the women who apply after they become pregnant or those who do not apply at all during the pregnancy. Though the bureau's social investigators may see these women several times during the pregnancy, they are generally not informed of the pregnancy until late in the second trimester, or not until the third trimester. In accordance with bureau directives, when they learn of the pregnancy they urge the women to seek care but do not make specific arrangements for them. In general, they do not succeed in counterbalancing the tendency of these women to defer prenatal care.

The school does not play a significant role in promoting early and regular prenatal care for school-age youngsters who become pregnant. Indeed, it often constitutes a deterrent to care because many youngsters try to hide the pregnancy from the authorities in order to finish the school term. In the majority of cases, school personnel are not aware of the pregnancy until fairly late, generally after the youngster has finally obtained medical care and social services.

### *Deterrents to Social Agency Care*

It is true that many unwed mothers lack any knowledge of social agencies, and others know only of the Department of Welfare or of hospital social service departments. Nevertheless, the most common deterrent to the fuller use of social services is not lack of knowledge, which deters only about a tenth of all unwed mothers. The important deterrent is the fact that the majority of unwed mothers see no need to contact agencies sooner or at all. Among those who have no social agency contact at all (almost 30 percent of all unwed mothers), roughly two-thirds see no need for any; four-fifths of this group would know where to go if they wished help. About 15 percent of all unmarried mothers do not seek social agency care sooner, or at all, because they are trying to conceal the pregnancy.

The prevalence of one deterrent or another to social agency services will depend, in part, upon the mother's age and ethnic group. For example, among the older unwed mothers and among the Negro and Puerto Rican groups, concealment is less frequently a deterrent than among the white group. For 43 percent of the white unmarried mothers, compared with only 8 percent of the Negroes and Puerto Ricans, concealment is a major deterrent. In contrast, about 60 percent of the Negroes and Puerto Ricans but only about 20 percent of the whites do not seek social agency help because they feel they do not need it.

In addition to the general deterrents to the use of social agency services which have just been mentioned, the following information was obtained about deterrents to the use of specific types of services and deterrents growing out of agency policies and practices.

About 88 percent of all unwed mothers are in contact with a clinic at some point in the pregnancy, but only 40 percent see the clinic social worker. The two main reasons for the gap are that the women see no need for the service or are already in touch with a social agency. But in 14 percent of the clinic contacts, the unwed mother's lack of knowledge about the service keeps her from seeking it.

Nearly two-thirds of the unwed mothers manage their everyday living expenses during pregnancy without any public aid; the Bureau of Public Assistance of the Department of Welfare is the sole source of income throughout the pregnancy for only 12 percent. Approximately 10 percent of the unwed mothers, however, have a serious financial problem during pregnancy yet do not apply to any agency for aid. Some in this group had sought help from the Bureau of Public Assistance in the past but were refused, and for this reason do not go again. Some, however, do not know where to go.

At the time the baby is born, about 7 percent of all unwed mothers have neither reached a decision regarding plans for the baby nor are in contact with a social agency for help in evaluating the various alternatives. Roughly half of this group do not know where to go. Most of the others assume that an adoption agency helps only if the unmarried mother has definitely made up her mind to surrender the child.

Agency eligibility criteria, except in the Bureau of Public Assistance, do not constitute a significant deterrent to agency services. In general, relatively few unmarried mothers are refused help when they ask for it. Six percent of the contacts with agencies with specialized services for unwed mothers, however, result in a refusal of service, primarily because the mother is not affiliated with the sectarian group served by the agency. A few unwed mothers are turned down because they come too early in pregnancy, and a few because of "closed intake" due to lack of facilities. Others are refused service because they have asked for types of help not within the function of the agency to provide. Of course, the effect of any refusal may depend upon whether or not the unwed mother is referred elsewhere. Only about half of the unmarried mothers refused help by specialized or other social agencies, and only about a fifth of those found ineligible by the Bureau of Public Assistance, were sent any place else for help.

In general, however, it may be said that if the unwed mother wants and seeks social agency help, she will usually obtain it. The chief deterrent is that she sees no need for service.

### *Conclusions and Suggestions for Action*

It is clear from this analysis that not all unwed mothers exhibit the same characteristics or follow the same pattern of use of services, and that no single deterrent explains the current use and nonuse of prenatal medical care and social services. It is evident, therefore, that no panacea can be offered. Rather, suggestions for eliminating or reducing the impact of obstacles to early prenatal care and social services have to be framed for each different group.

The major deterrent to care among teenagers reflects society's attitudes towards illegitimacy. This is the effort, frequently successful, to conceal the pregnancy for a considerable period. If the impact of this deterrent is to be eliminated or reduced, it will have to be done through school personnel and the youngsters' parents, since these are the people in daily contact with them. The report recommends that school authorities take on greater responsibility for detecting pregnancy early

and for maintaining subsequent contact with the girls to ensure that medical care and social services are obtained early and regularly. It also recommends that certain changes in school policies be instituted to remove and reduce the incentive for concealment.

By and large, the white unwed mothers who are seventeen and older seek and obtain medical care and social services. Though no specific proposals are made for the minority which does not, this group would probably benefit from many of the suggestions made for other groups of unmarried mothers as well as from some of the suggested changes in agency policies and practices.

Since about half the Negro and Puerto Rican women giving birth to a child out of wedlock in any one year will be having their second or third out-of-wedlock child, several avenues of action might be explored in the effort to overcome the deterrents to prenatal medical care among these women, through both the inpatient and outpatient services of municipal and voluntary hospitals and through the Department of Health child health stations. These facilities provide opportunities for health education and for referral which could be more fully exploited if sufficient staff were available and appropriate arrangements were made. Clinics might also consider some revision of their eligibility requirements with respect to area of residence in cases where unwed mothers request service at the "wrong" clinic. It is suggested, too, that the Bureau of Public Assistance might play a more active role in promoting early prenatal care for its clients by more intensive staff training programs for social investigators with regard to the problem, and by the establishment of policies and procedures whereby social investigators may make specific arrangements for the unwed mother for clinic care and follow-up. Effective implementation of the recommendations vis-a-vis the Bureau of Public Assistance will, of course, require additional qualified personnel.

In dealing with the question of how to overcome deterrents to social agency services among Negro and Puerto Rican women seventeen years and older, one must consider separately the various types of social services, shelter care, adoption service and counseling. It would undoubtedly be generally agreed among those concerned with the welfare of unmarried mothers and their children that counseling services should be provided to all unwed mothers. Efforts must be made, therefore, to reach the large group of Negro and Puerto Rican unwed mothers who do not obtain any social agency services at all. If sufficient personnel are not available in the short run to accomplish this, the effort to "reach out" might well be concentrated on the younger women who are having their first out-of-wedlock child.

More Negro and Puerto Rican women could be reached if more unwed mothers who obtain prenatal care at clinics would also see the clinic social worker. What apparently is required is a closer liaison between the medical or nursing staff and the social service department, and the establishment of administrative policies in the hospital to ensure that every unwed mother is reached by the social worker. Clearly, this would require more trained social workers. If shortage of personnel requires some limitation on the number served, screening devices might be established so that those who can most benefit from counseling services could be reached.

Though it is reasonable to establish immediately the goal of providing casework services to all Negro and Puerto Rican unwed mothers seventeen years of age and over, a goal of providing all of them with shelter care and adoption services is neither realistic nor necessary at present. Unwed mothers in this group generally want to keep their children. By and large they do not wish, and have no need for, either shelter care or adoption services. Though it is true that the dearth of community resources for the placement of Negro and Puerto Rican children may influence the decision to keep the child, what is needed most urgently, nevertheless, is counseling and supportive services before and after confinement to help Negro and Puerto Rican unwed mothers to maintain a home for themselves and the child. The clinic social worker appears to be the most direct resource for providing counseling services before confinement. For counseling services after confinement, the social service program in the child health stations might be expanded to provide service to all unwed mothers who plan to keep their babies.

About two-fifths of unwed mothers go to a private doctor initially when they realize they are pregnant, and frequently they see him in the first trimester of pregnancy. The private doctor could, therefore, exert a crucial influence towards encouraging continued care if he played a more active role in referring and following up the unwed mother to ensure contact with an appropriate agency. With respect to community agencies in general, it may be said that once an unwed mother contacts either a clinic or a social agency, the community shares with her the responsibility for ensuring adequate medical care and social agency services. In view of the numerous possibilities of unwed mothers' getting "lost," community agencies should agree that the agency of original contact will take responsibility for the unwed mother until she is actually in touch with another and more appropriate agency.

If the community wishes to take action to reduce or eliminate existing deterrents to prenatal care and social services, it must be ready, first, to adapt its programs to serve those who need help. Second, it must be ready to meet the demand it will be encouraging by expanding services and facilities as needed, including additional shelter care and adoption services for those who wish to place the child, and counseling and other supportive services to unmarried mothers who keep their babies. In the long run, one may hope that if appropriate services are made available to unwed mothers, particularly to the younger girls who are having their first child, the pattern of behavior can be changed.

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## SOME RECENT PUBLICATIONS*

*Exploring the Base for Family Therapy,* edited by Nathan W. Ackerman, M.D., Frances L. Beatman and Sanford N. Sherman, Family Service Association of America, NYC, 1961. 159 pp. $4.00. Papers from the M. Robert Gomberg Memorial Conference.

*Jobs and Salaries in Health and Welfare,* The Welfare Federation of Cleveland, 1960. Volume I, 163 pp. Volume II, 356 pp. Two-volume set, $10.00. This study presents a comprehensive job classification plan and salary range guide for all jobs in the social welfare field in Cleveland.

*Protecting New York City's Children,* Dr. Alfred J. Kahn, Citizens' Committee for Children of New York, Inc., 1961. 48 pp. $1.00. Describes the increasing seriousness of child neglect in New York City. Proposes establishment of a protective casework program in the Department of Welfare as the only practical way to prevent and correct neglect and reduce delinquency.

*Recruitment for Social Work,* Elizabeth R. Jacobs, National Association of Social Workers, NYC, 1961. 72 pp. $1.25. Prepared by the Medical Social Work Section of the NASW. Gives pointers for a recruitment program.

*Strengthening Public Welfare Services Through the Use of Volunteers,* American Public Welfare Association, Chicago, Institute Report VII, 1961. 39 pp. $1.00.

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* Available on loan from League's library.

# THE BOARD MEMBER'S PRIORITY JOB*

*Mrs. Lawrence S. Fletcher*

**Board Member, CWLA**
**Piedmont, California**

***A frank, thoughtful examination of the financing problems faced by voluntary children's agencies, and the avenues open to agency boards to obtain more funds.***

THE board of an agency is responsible for the kind of service that an agency provides and for its quality. The board's responsibility for the agency's financial support, therefore, is of primary importance. I wish I could put an electric charge into these words, because this phrase has recently taken on an extremely important significance. We are all right back where we started years ago, faced with the urgent responsibility of directly obtaining sufficient funds to permit our agencies to operate. And it is the board member who has to do it.

Back in the late 1800's, when the San Diego Children's Home Association, as well as most of the other children's institutions in the West, was founded, the community responded to the needs of orphans. Homes were established and run by a small staff who took care of the physical needs of the children. Board committees were in charge of admissions, purchasing, etc., and at the same time managed to raise enough money to keep the institution going. Most institutions did not accept problem children and these were passed from home to home, finally landing in large institutions or in homes with conditions so bad it is best not to remember.

### *Federated Financing*

With the advent of Community Chests in the 1920's, harrassed communities everywhere began accepting the idea that a unified campaign would be best for everyone. Agencies welcomed the plan. The concept of deficit financing came later. We are all familiar with the evolution of the Chest into the United Fund and of the advantages and shortcomings of these plans. Of course, the greatest shortcoming is that the Funds today do not produce enough money!

### *Factors Affecting Voluntary Giving*

Let us try to understand the problem. Imagine a pyramid. The base represents those services which have received the understanding and support of more than 50 percent of the community. They are mostly tax supported because enough people wanted them to produce a majority vote. As you go up the pyramid, fewer people believe in a service, but enough of them want it to pay for it themselves. The United Fund agencies belong in this group. It follows, then, that voluntary agencies are addressing a minority of the community when they ask for support. But this is nothing new. Why, then, are agencies and the United Fund suddenly in this predicament? Who, or what, is the culprit?

1. The level of the base of our pyramid has risen. So many of the former voluntary agency functions now have become tax supported that the remaining ones are more difficult to interpret and more expensive to operate.

2. The effect of the income tax on charitable giving is beyond estimate. It has siphoned off income so that there are very few individual big givers. In the same way it has affected bequests. Even the tax benefits available to the donor do not ameliorate the situation. Instead of direct giving to an agency, private foundations have been established with a different pattern of giving. The era of private philanthropy appears to be ended.

3. The development of many national health associations is responsible for the diversion of a large share of the local agency dollar. Most of these health agencies disregard the effect of their campaigns on fundraising for the local agencies. They also have proved reluctant to give up a good thing should their initial drive to eradicate an illness prove successful.

* Given at the 73rd Annual Meeting of the San Diego Children's Home Association, May 16, 1961.

### *Methods of Increasing Support*

What, then, are the alternatives for increased agency support?

1. Agencies can raise money through a multitude of ways-and-means events. They can have campaigns for memberships or they can raise their fees. These efforts, formerly effective, today unfortunately are insufficient, but they all help.

2. Agencies can put greater effort into the United Fund. This is their obligation, but it too is not a complete answer. The Fund here, for instance, is not falling short entirely due to lack of leadership and volunteers. This is a national picture.

3. Agencies can apply to foundations and corporations for gifts. For many reasons, this is not a permanent solution. Money can be obtained, agreed, but who is going to pick up the tab after the grant terminates? This is true, too, of Federal grants, which usually are for research and do not help the everyday operating budget problem. I do not mean to imply that agencies should ignore these sources, only to point out that they offer no permanent solution to the problem at hand.

4. For the children's agency there is one last alternative—the local public agency. This is no pot of gold. In many ways the public agency is in as bad a financial situation as we are. They are required by law to give services and are limited by the tax dollar as to how much they have to spend. However, the purchase of service from private agencies can be a distinct benefit to both.

### *Advantages and Disadvantages*

From the public agency side, this plan can provide specialized services better and less expensively by purchasing these services rather than supplying them itself. The advantages are also distinct for the voluntary children's agency. At the present time, most private agencies take public agency cases, but the reimbursement rate is far below the per capita cost. There always has been deep question as to whether private agency funds should go to children who are eligible for care through tax funds. When the public agency pays its legitimate share, private funds would be released to provide for the other children, and the agency budget would be in a less precarious state.

Admittedly, there are also disadvantages. If the public agency, which has a large number of children needing specialized services, were to purchase a considerable amount of these services from private agencies, this could mean that there would be fewer resources for children ineligible for public agency services. Another disadvantage is that public funds entail increased bookkeeping, better cost accounting, and a certain loss of autonomy. Also, there would be the problem of "co-operative" cases. These problems require careful study and will be solved by each agency board according to its own philosophy. Adding the pros and cons, this plan remains, in my opinion, the best solution for children's agencies.

### *The Image of Social Work in the Community*

But how to do it? The way is difficult but clear. As a first step, voluntary agencies must improve their "image."

The high cost of services is difficult to interpret. Per capita costs of $500 a month and more, usually more, can be depended upon to create a negative reaction unless accompanied by an explanation convincingly stated.

The public has a very poor image of social workers. Part of this may be due to the nature of their job, particularly in a public agency where eligibility requirements for aid create the inference of power. Many of social work's past struggles have built up attitudes in some parts of the community which must be lived down and about which, to my knowledge, no conscientious effort to eradicate is being made to date. It is said also that there is an unconscious community guilt about having produced these children who are so badly in need of care, and that this affects our image. One thing which makes establishing a new image difficult is lack of a popular cause. Problem children are not appealing. The public would prefer not to have to be troubled by them.

On the positive side, however, is the basic community goodwill. No agency could exist for seventy-five years if it did not have many friends. Board members, volunteers, and the agency's constituency are invaluable media

(*continued on p. 33*)

# HOMEMAKER SERVICE FOR FAMILIES WITH MENTAL DISORDERS*

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***How homemaker service helps the family when one parent is psychiatrically disabled.***

*This is the first of two articles on homemaker service for families in which one member has a mental illness. The second article, "Homemaker Service for Children with Psychiatric Disorders," by Nora Phillips Johnson, will appear in the November issue.*

Some agencies have been experimenting with homemaker service for families where there is psychiatric disorder, often with considerable success. Others have been reluctant to undertake homemaker service for these families, partly because traditionally homemaker service has often been viewed as a short-time service. Psychiatric problems cannot be bound by time limits; they require that we be flexible and tentative with regard to the period of time the service might have to be given. Unless we can develop such an approach, it may well be difficult for us to use the service creatively, or to exploit it to its maximum potential.

Let us examine the matter of the time limit for child care in general. We assume community responsibility, through public and voluntary agencies, for child care; we set no time limits for foster care. We agree that it needs to be available so long as it is the most feasible form of care for a child. Yet we often do not extend this flexibility to homemaker service, despite the fact that it has proven itself a desirable form of child care and would often be the best choice, and even the most economical one, in a given situation.

Thus it would appear that there is an illogical contradiction in our total approach to the care of children. We deny the client and ourselves the possibility of making a choice between placement or keeping the family intact. The reluctance to make homemaker service available in lieu of long-time placement does not take into account the fact that homemaker service is a direct service to the family as a whole: not only does a single homemaker render child care, regardless of the number of children in the family, but she also serves adults who are often ill and disabled and might otherwise require costly hospital or institutional care. We need not stress here the emotional and psychological values of keeping certain families together. This does not negate the values of placement, but it does mean that we need a true choice of the service which will have the greater meaning for a family.

If we should come to an acceptance of homemaker service as still another resource for long-time care of children, it would seem necessary for the public agencies to assume their share of financial responsibility by subsidizing it. This would pertain whether the service was given within the framework of the public agency or in collaboration with a voluntary agency, the present pattern in foster care. It would seem almost impossible for sufficient *voluntary* funds to be made available for such a program.

### *The Role of the Psychiatrist*

Where a homemaker service agency accepts responsibility for serving families with psychiatric problems, it is imperative to have psychiatric consultation as an integral part of the service. The psychiatrist might serve on a panel basis, be connected with a state mental health facility, or be a staff member.

Including a psychiatrist on the homemaker service team can be a protection for the pa-

* Given at the CWLA Eastern Regional Conference, New York City, on April 20, 1961.

tient, family, community and agency. The agency must have a sound medical opinion on which to base its decisions. In giving homemaker service for health reasons, whether physical or psychiatric, the agency is generally dependent on medical or psychiatric reports obtained with the patient's or family's consent from the treating physician, whether private, hospital or clinic. Where the illness is physical, the social worker can often use such reports as a guide for administering the service. However, where psychiatric disorders are involved, evaluation seems more complex. Psychiatric problems may not always lend themselves to clear diagnoses and prognoses, and should more than one psychiatric opinion be involved, the diagnosis, prognosis and treatment plans might even seem contradictory.

Thus we can see what the differential role of a psychiatrist as consultant in homemaker service, either on a panel basis or as a staff member, might be. Where the diagnosis, prognosis, or recommendations given by psychiatrists in the community seem untenable or confused to the social worker, there are a number of ways in which the agency psychiatrist might be helpful. The caseworker could request that the psychiatrist review the reports for purposes, a more difficult problem since there is a not effective, the psychiatrist-caseworker team might then consider other possibilities. The psychiatrist might attempt to get further clarification directly from the other doctors involved, who may feel freer in giving information to another doctor than to a social worker. Also, the agency psychiatrist might interpret the service to the other doctor. At times it might be necessary, as the only sound basis for planning, for the agency to require the patient to be seen directly by the agency psychiatrist; in many instances the patient has never been seen by a psychiatrist. It could be helpful, especially in emergencies, to have an agency psychiatrist take part in the diagnostic study. The availability of such an authoritative medical report can be most effective in planning with a family in crisis.

Psychiatric services for diagnostic purposes are often available either within the agency itself or in the community. However, the search for psychiatric help beyond diagnosis poses a more difficult problem since there is a shortage of psychiatric treatment services in most communities. Even where it is available it may be too costly. Some form of hospital care can generally be found, but families are frequently reluctant to consider a state hospital, and often seek a private one. The use of drugs along with outpatient treatment is sometimes an alternative to hospital care, but an agency would have to insure appropriate medical or psychiatric supervision of this therapy. While outpatient services as well as hospital day care are expanding, they still fall far short of need.

Where the needed psychiatric services cannot be made available and where a family should be kept intact, the dilemma would be whether homemaker service alone could safely be used. Might a modified goal be valid, or does placement of the children need to be considered? There are times when realities force us to lower our sights. This need not immobilize us, if we have a clear understanding of our goals.

### *The Role of the Homemaker*

Aside from concern with length of service as related to cost, and shortages in professional and psychiatric resources, it seems that our image of the homemaker herself may help to determine whether we offer homemaker service in psychiatric situations. Do we see the homemaker as a semiprofessional person who can be part of a team approach in carrying out a psychiatric service? We have not yet formalized the job of homemaker as a recognizable and defined prestige occupation requiring standardized training or certification. Thus we struggle with a variety of devices for training homemaker staff. It is increasingly evident that we need to develop uniform standards as a guide to recruiting and training. Nevertheless, despite these handicaps there has been considerable experience in using homemaker service effectively in families with psychiatric problems.

We are familiar with the qualities we seek in any homemaker at the time of recruitment: motherliness, for example, and warmth, flexibility, initiative and judgment. Aside from life experience, it can help if the homemaker comes with related training and experience. However, in recognition of the psychological

component in homemaker service, it would seem essential for the agency to evaluate the applicant's capacity for growth, change and learning. While this is not identical with the potential we seek in a caseworker, there are comparable elements in the two roles. Once we have employed a homemaker with good natural qualities and life experience, her development in the psychological aspects of the function then depends in part on the in-service training program, the ongoing supervision, and her role as a member of the team of psychiatrist, caseworker and homemaker.

It is the psychological aspects of the homemaker's function which differentiate her from the private housekeeper—the need for her to balance her identification between the agency and the family, for example. She has to set aside many of her personal judgments and attitudes, and needs to have a basic understanding of family relationships and child care. In addition to what is required in any homemaker situation, there are inherent specifics where there are psychiatric disorders.

Aside from an appreciation of the impact of any illness, the homemaker would have to learn as much about mental illnesses as her own function would require. She might need to understand the difference between neurosis and psychosis, and in a general way, why a recommended plan might be hospitalization or outpatient care. She would need to understand depression, or why a mother suffering from post-partem depression might have bizarre attitudes towards the baby. The psychiatric placement is a very demanding one for the homemaker. She is not a psychiatric nurse, yet she may be required to spend long hours with a disturbed patient. The homemaker would have to learn to be sympathetic and supportive, without getting involved with inappropriate interpretation or invalid reassurance. She would need to know what to report back to the caseworker, or how to participate in a team conference. She would also have to be ever alert to any complications which might require her to involve the agency on an emergency basis, and possibly even the responsible family member directly.

On assignment to a case, the homemaker needs full and careful preparation by the professional person responsible. This includes the nature of the illness, the problems resulting which might affect the help she gives, the purpose and goals in giving the service. The family needs to understand the professional component in the homemaker's function in order to accept her knowing about the illness as a basis for the service.

Once on the assignment, the homemaker needs continuing supervision. She would have to be kept apprised of any medical or psychological changes which might have an impact on the planning. She might be included in the team conferences with the psychiatric or psychological staff where her role could be dual—reporting out of her close association with the patient and family, as well as gaining more perceptive understanding of her function. Her role with the family itself would flow from the needs of each given situation. She might be a mother figure not only to the children but to either or both of the parents as well. She could help towards restoring healthier balances in the family relationships, provided the caseworker were family oriented rather than patient centered.

### *Goals in Homemaker Service*

Since for emotional and cultural reasons the inclination of most families is to remain intact, they naturally seek homemaker service. The professional, too, views this as desirable. Nevertheless, homemaker service should be used selectively, and not be seen as a panacea. Other services might be more appropriate in a given situation. Psychiatric problems seem to arouse anxiety not only in the patient and family, but in the homemaker and professional staff as well, and thus a high level of skill is required to arrive at a sound evaluation with regard to the use of homemaker service for these families.

There can be differential uses and goals in homemaker service where there are psychiatric problems as in any other situation. A variety of plans may be required, each in keeping with changes as they occur. Short-time care might be required for an indefinite period. The hours should be offered with flexibility, from brief part-time service to round-the-clock

service in emergencies. As with any other health or welfare service, there are times when we have to take risks. The service can be used to explore its possible applicability, or as an interim holding operation while working towards a more suitable plan. In psychiatric situations particularly, we often need to start with the tentative. The outcome may not be clear at the outset.

### *Giving Homemaker Service on an Emergency Basis*

Let us review types of psychiatric situations where a request might be made for homemaker service. One of the most difficult is the situation in which a mother in a psychotic episode has attempted a suicidal or homicidal act. This would naturally engender anxiety and an overwhelming sense of pressure in both client and agency. Here we are dealing with a matter of life or death. The decision as to whether such an individual can remain in the community even for an exploratory period, or whether hospital care on an emergency basis is indicated, is a grave one indeed, and cannot be made without the medical opinion of a psychiatrist. One of the determinants would be whether the act was one of gesture or intent. Was it a desperate way of calling for help through a gesture not meant to eventuate in destruction, or was the patient's intent truly to destroy her own person or that of another?

While a psychiatrist must make a direct examination of the patient, the caseworker too can have some clues, through her own work with the family, as to whether to risk giving homemaker service on an emergency basis. At times, the patient herself, depressed as she is, might initiate the request for service. This might be an indication of her will to live, and some assurance that the suicidal attempt might not be repeated. Where the family makes the request, the service might be considered with the patient remaining in the home, at least at the outset, only if there were genuine participation by the patient in planning the service. The possibility of tangible relief through homemaker service often seems to ease the desperation, so that the risk of suicide is remarkably diminished. However, were the mother so depressed that she could not be at all involved, it would almost seem to be a clear indication that she requires hospitalization.

Where there is such a disturbed patient in the home, an agency cannot place a homemaker unless there is assurance from a psychiatrist that it would be reasonably safe for all concerned. Where immediate hospitalization is recommended and the family is still not ready to follow through, the agency would then have to withdraw. It could not, through homemaker service, underwrite a plan which was not valid, though some casework might continue to help the family move towards necessary planning.

Placing a homemaker on an emergency basis in a situation such as this would have to be viewed as a first step in planning, without any commitment with regard to time or ongoing service. There are many different directions in which a case can go, predicated on such elements as the strengths in the family, the values of the respective family relationships, the possible impact of the mother's illness on the children, the availability of the needed psychiatric resources.

The homemaker might be placed for a study period while determining whether the mother needs hospital care or can remain at home with an outpatient treatment plan. Often, despite a gesture of violence, once both psychiatric and homemaker help is used it is possible to keep the patient at home. Where hospitalization is recommended and private hospital care is sought, there might be a waiting period for a bed. We would then need a psychiatric opinion as to whether it were safe for the mother to be home for such a period, or whether the family would have to resort to placement in a state hospital.

During this study period, a further consideration would be the matter of planning not only for the mother, but for the children too. Careful thought would have to be given to how the mother's illness might be affecting them. Some families may need help to care for their children through placement, especially where the father is not too strong, or where the children are very young. Because of pathology, possibly in both parents, placement might be the healthier plan for the children. For other families, however, it could be important for the patient, father, and children to remain together as a family, even where the mother might need hospitalization for an extended period. Homemaker service might make it possible for the mother to have day care in a

hospital, or to visit at home sooner and more frequently. In addition, it might mean that she could be discharged on convalescent care much earlier.

Of course, in some families, the mother may have to be away for many years. Here again the question of keeping the children at home with the father would depend on the value for them of staying at home as compared with what placement might have to offer them. The patient and family may not be ready to consider placement when the decision about hospitalization is made, or in the beginning period. Often so much psychic energy is invested in planning for the mother that it might be difficult to become involved in the question of the children's placement. In addition, it can be extremely difficult to face the trauma of separation simultaneously through the placement of both mother and the children. Through the use of homemaker service, the father and children would have an opportunity to experience the realities of the mother's absence and the limitations inherent in homemaker service, no matter how flexible or extensive. Then should the need for care become extended, there can be a sounder evaluation with regard to choice of service—care at home or placement.

### *When the Patient Remains in the Home*

There are many psychiatric disorders which can be treated on an outpatient basis. Some patients find the beginning period fraught with many difficulties. The inner pressure of the illness itself which propelled the patient into treatment, and the initial conflict and resistance to treatment may well be overwhelming, possibly resulting in severe depression. Such patients can be helped through homemaker service. They may need relief from the reality pressures of family responsibility. At the same time, the service can help protect the children from the mother's disturbance. This in turn may facilitate the treatment process, so that the patient might recover more quickly, and be enabled to resume self-responsibility.

Then there are the chronically ill patients who are not accessible to treatment, even were it available. Such individuals can often continue to function in the family and community. There might be danger of breakdown at times of stress. With psychiatric evaluation as needed, we are able to determine whether homemaker service can be effective. Some families might require a homemaker periodically, either during a specific crisis, or at those times when cumulative pressures require service to prevent a breakdown. Often families may need the homemaker for long periods to hold the family together. We need to know, through the psychiatric service, whether homemaker service alone can suffice, or whether it would be ineffective unless there were some supportive treatment for the patient. And we would have to insure that the mother's illness would not have a destructive impact on the children. Actually, it would seem that the use of homemaker service where there is a chronically ill mother may be a protective device for the children, and a mental health service in terms of preventing the children from developing psychiatric disorders.

### *Summary*

Homemaker service can be used for families with psychiatric problems, if we corral the resources and skills essential to carry out such a service, and if the agencies, both public and voluntary, can get past the limiting traditional attitudes towards the time aspect and accept homemaker service as a basic form of child care, in the same sense that we have long since viewed foster care. Often the problems of families with psychiatric disorders cannot be solved by homemaker service alone but require a variety of psychiatric services, along with the family's capacity to use them. At the same time, were psychiatric resources not available, we would have to determine whether modified acceptable goals could be achieved through the use of homemaker service alone. The service cannot be patient centered, but must concern itself with the family as a whole. Naturally there is particular concern for the children.

On the whole, the use of homemaker service for psychiatric problems challenges us to call on every skill at our command. While we still have much to learn, it would seem that by now we have had enough experience to affirm that homemaker service can be helpful to many families confronted by mental or emotional illness.

# FAMILY DAY CARE AND GROUP DAY CARE: TWO ESSENTIAL ASPECTS OF A BASIC CHILD WELFARE SERVICE*

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***The child welfare field bears some responsibility for seeing to it that both family day care and group day care are provided and that programs utilize the skills of the medical and education professions as well as of welfare itself.***

A DAY nursery is often among the oldest social agencies in our communities, yet day care service is still considered by some to be experimental, something new almost to the point of being untried. It is true that much of what is called day care service today more closely resembles the kind of program offered in 1856, at its beginning in this country, than it does the concept of what day care *can* be today.

Even 106 years ago, nursery care was conceived of as a service to supplement the family's care of the child during the day, paying attention to his needs and protecting him from the problems of his environment. With sensitivity, creativeness and devotion, day care programs utilized what was then known of medicine, nutrition, hygiene, and child development, and tried to provide a service to meet the social problems of the day.

Day nurseries were among the first agencies to have the "friendly visitors" who were the forerunners of the profession of social work. Day nurseries introduced kindergartens to the United States and proved their value before they became part of the regular school systems. Similarly, day nurseries introduced the Montessori system of education and the nursery school to this country.

But how many nurseries do not have caseworkers as an integral part of the service today? And how many day care agencies today are without the benefit of qualified educational services as an integral part of their program?

Too many programs are just going through the old-fashioned motions, ignoring the basic *intent* of day care. In an earlier era, the agency that helped parents to carry their responsibility by serving the child all of his meals in the nursery, and by bathing him and shampooing him there, did so in the knowledge that his mother worked ten or twelve hours a day, had no facilities for bathing the child, and had neither time, money, nor energy to provide reasonable care. The agency that automatically provides these or similar services today because it has always done so, without regard to the changing social and economic conditions, is not being equally helpful.

The agency which keeps intact the basic principle—whether treasured over the century or newly arrived at—of providing a service that supplements the family's care, and which does so in ways that support and strengthen the parents' ability to retain their responsibility for the child's care, can move ahead with developing resources and new knowledge in meeting changing needs.

The community as a whole, as well as social agencies, is frequently not aware of the constantly changing methods for carrying out the basic principles of the up-to-date day care program. The failure of many children and parents to get the fullest potential benefit from the day care program is often due to the lack of understanding on the part of the referring agency, which thinks of day care as merely a custodial service, meeting daily physical needs of the child while keeping him safe and relieving the mother of his care. The general lack of understanding sometimes leads to the community's failure to provide the day care agency with the resources necessary for a truly constructive program.

Day care is not, in fact, very generally understood as a child welfare service. When a good agency emphasizes its educational program, it is frequently regarded as belonging to the field of education. Because to the naked

* Drawn from a paper given at the Eastern Regional Conference of the American Public Welfare Association, Grossinger, N. Y., September, 1960.

eye a group day care program for preschool children is indistinguishable from a nursery school or a kindergarten, the illusion is often created that education is its purpose, and the demand for its service is frequently made in these terms. Such use of day care, in fact, may even contribute to a community's failure to develop adequate kindergarten and nursery school facilities.

### *The Purpose of Day Care*

As a child welfare service, the purpose of day care is to provide supplementary care for children during daytime hours when their parents are unable to provide for their care—and when day care is determined to be the best solution. It provides care for the child in such a way that the parents are enabled to maintain as much responsibility as is both possible and constructive. The most common problems creating the need for care are: the absence of the mother from the home because she is working (as a result of financial pressure, dissatisfaction with the concentrated role of homemaker, competition of interest in a personal career, or fear of inadequacy as a mother); absence of the mother from the home because of illness or death; illness in the family; strained parental relationships; problems of parent-child relationships; or greater than usual need for the child to have the benefits of a group experience away from home.

The two kinds of day care service, family day care and group day care, should be available. *Family day care* is the only form of day care suitable for children under three years of age. Often it is the preferred form for certain older children who have some specialized need for individualized care in a family setting or for whom group care would involve a disturbing displacement from the home community; it may also be preferred for a group of siblings who should remain together, when one of them cannot use group care.

The *group day care* facility is suitable for children who can benefit from group experience while being cared for—many three-year-olds and most children four and over. For preschool children, care is needed throughout the day; for school-age children it is needed when school is not in session—before school, during the lunch hour, after school, and during holidays and summer vacations. Although some communities provide care for children up to eleven years of age, and a few until twelve or thirteen, others offer no service for children above five. Few communities provide much care for children over eight. That six-year-olds or even nine-year-olds cannot take responsibility for themselves throughout the day should be obvious but apparently is not.

When a single agency has both family and group day care available, the child is most likely to obtain the kind of care suited to his needs and to change from one to the other as his own needs determine. Very few of the agencies providing day care service have this potential flexibility. Some communities that cannot prevent the need for day care (and this is every community) completely lack appropriate services for children of some age groups. Thus, they may expose some to unsuitable and even dangerous experiences—for example, group care for infants, or a single eight-year-old in a program planned for four-year-olds, or programs providing a poor quality of care.

In addition to meeting the needs of all children for food, sleep, play, exercise, and guidance, there is the very large responsibility for providing a plan for each child as determined by his own development and his family's situation; in group day care, there is the responsibility for carrying out that plan within the group curriculum.

### *Day Care's Difference Must Be Understood*

In a day care service, the responsibility for providing for the individual child's needs is considerably greater than in other forms of daytime children's programs. This is because there is some problem which makes it necessary for the parents to have help in carrying out their responsibility to the child, and necessitates care for the child for longer hours than are desirable on the basis of his educational and social needs alone. Thus, correlative services are required. It can be anticipated that there will be needs in certain day care groups related to the particular reason for the care. For example, a day care program for the children of migrant farm laborers will usually need academic work for the children who are educationally retarded because of their migratory life, and will almost always need addi-

tional health care as well. When day care is provided for the purpose of helping a family to care for a child who is mentally retarded or physically handicapped, the daily program will need some adaptation of its well-balanced curriculum of play, intellectual stimulation, good physical care, and guidance to provide appropriate developmental opportunities to the child and to his parents as well. When the day care service is provided to families that have problems of parent-child relationship, the service will involve sensitive and skilled individualization of the child's guidance related to his particular need in the situation as well as appropriate help to the parents.

The total program of day care requires the skills of three professions—medicine, education, and social work—and it requires that these be integrated if the service is to be truly useful within a child welfare definition.

### *The Importance of Work with Parents*

In any day care service, there needs to be considerable responsibility for a program of direct work with the parents in relation to the use of the day care program itself, and also in relation to other pertinent problems. For example, a program providing excellent direct care of a child may be unaware that by failing to give appropriate parent guidance based on understanding of the problem, it is contributing to the family's increased willingness to dump all responsibility for health planning, intensifying a mother's feeling of low self-esteem over being unable to manage her responsibility for her child's guidance and discipline, or playing into a father's lack of concern about contributing to his child's care and support. It may, on the other hand, be so accepting of the mother's problem that it fails to take into account the child's real need. A child may thus be forced to adjust to being left in the day care program without a gradual initial introduction to the service, because the agency has taken for granted the mother's statement that she cannot arrange for a series of short visits by the child, or for a stay with him while he visits. A day care center may fail both the child and his parents by not seeing the real nature of the relationship between the child's behavior in the center and the mother's feeling about sharing her responsibility.

One five-year-old was unwilling to eat anything in the center other than bread and milk, and canned soup brought from home, because she felt disloyal to her mother, who was torn by the little girl's ready acceptance of the rich day care experience. The skilled teacher's frustration at continued failure to improve the child's eating habits and the mother's anxiety at being unneeded could result only in squeezing between them a sensitive child of great potential. They needed to learn to work together, with the help of the caseworker, so that the day care experience would in no way be competing with the home and the mother could really accept her need to share responsibility for the child's care.

In family day care, the potential problems of the parents' sharing the care of a child are somewhat greater. The child's own mother tends even more toward dumping responsibility onto the daytime mother and, conversely, toward even greater resentment of a successful day care placement. Unless there is considerable assistance to both women from skilled supervision, the child is likely to be exposed to constant re-placement or to being in the middle of a battle, with the day care "mother" and the parent vying in demonstrating affection and the ability to provide good mothering—if he does not fall into the abyss of relative neglect.

### *Responsibility for Providing Services*

While family day care is rather readily accepted as a child welfare service, the welfare field itself provides very little of it. Parents too often discard it as a potential service even when it is available. Because its welfare aspect of substituting parental care is so obvious, they tend to prefer group care even for infants because it masks itself as a school, which is a "nice" thing to provide for a child. The number of social agencies accepting the idea of group day care for babies and tiny children with little or no question, even where it is prohibited or restricted by law, is startling. It is good to note that the practice is, at least theoretically, increasingly frowned upon. No doubt group day care for babies will not cease until more nearly adequate family day care, both in quantity and in quality, becomes a reality. This will surely be a result of responsibility taken within the field of welfare itself.

The responsibility for providing group day care has a more nebulous aspect. Since it resembles education and recreation, and since a

service agency is frequently derived from a program originally providing for one of these purposes—and indeed must itself incorporate basic aspects of both—group day care tends to be regarded as the business of education and recreation as well as of welfare. But everybody's business tends to be nobody's business. Unless the greatest care is taken in the integration of responsibility shared by agencies representing various specialized services, the multi-discipline but basically welfare service of day care is shunted into the corner.

Some combinations of municipal agencies, and some combinations of municipal and voluntary services, are able to keep policies clear and maintain lines of responsibility while providing real support for active programs. Others, careful not to interfere with each other, are almost equally careful not to assume any aggressive responsibility for the maintenance or development of needed day care service.

Is it welfare *or* education that operates day care service? Or is it welfare *and* education? Or is it welfare saying that the lack of service is education's responsibility and education saying that the problem is welfare's? And where are public health and mental health in all this?

The fact that group day care as an agency service is more readily available in most communities than is family day care is undoubtedly due to two factors. One is that when group day care is provided by an individual as a proprietary service the community eventually becomes aware of any shortcomings it has and takes steps to require the maintenance of at least minimum standards. Thus, the closing off of some private resources of poor quality will make evident the need for developing community-supported services. The other, and perhaps more significant, factor is that the varied aspects of group daytime programs for children have led to their provision by multiple sources. Settlement houses, schools, welfare departments, churches, family service agencies, and factories, as well as day care agencies themselves, have all contributed, and continue to provide, some services.

The ability to use recreation and education programs to provide some aspects of day care service, and to use good day care services for providing some aspects of recreation and education, has led to a few notable programs of multi-purpose service providing excellent day care: the All-Day Neighborhood Schools of the New York City public school system, for example, and the Play Schools Association program conducted by that voluntary organization in conjunction with the New York City schools. On the whole, however, the duplication or indistinctness of needs and services has led to the failure of communities to develop facilities for meeting adequately all of these needs. The most vocal and aggressive of parents and professional workers tend to devote their energies to locating service for some particular child (a kindergarten or nursery school experience, or an opportunity for a handicapped child to play with other children, or observation in order to diagnose a child's problem, or relief from overcrowded housing, or day care) rather than attempting to provide sufficient services for all of these needs, or indeed to provide a well-developed, effective service for any one of them.

The field of child welfare has, in general, taken up only one aspect of its responsibility for day care. This is the area of licensing and supervision by public agencies. Assumption of this responsibility is the result of the recognition that many children who had to be away from their homes during the day were inadequately protected. Often the care they received was not only inadequate for their needs but actually dangerous to their health and welfare.

With a few notable exceptions, including New York City and Philadelphia (although neither of these has increased its services significantly in spite of increasing need), there are hardly any group day care programs under public welfare auspices. And voluntary support of day care programs as child welfare services, through the United Fund or other sources, seems to be suffering from attrition in many communities.

Day care as a child welfare service appears to remain largely in the future. Insofar as day care, as a service to supplement care ordinarily provided by the family, *is* a child welfare service, the child welfare field bears some responsibility for seeing to it that both family day care and group day care are provided, and that the programs utilize the skills of *all* the professions needed—medicine and education as well as welfare itself.

# PSYCHOLOGICAL IMPLICATIONS OF LONG-TERM FOSTER CARE*

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***An early and consistent approach to help children master the trauma of placements.***

For the child in long-term foster care, several deleterious factors impede or distort the intrinsic drive towards psychological maturation. These factors begin to operate in the natural family, prior to placement, and are generally the basic reasons for placement. Thus one finds such reasons as inadequate mothering, parental abuse or rejection, and mental illness in the mother in a large number of case records.

Long before he is placed, the child has developed methods of relating to his family, of coping with feelings aroused by such rejection or neglect. These modes of adaptation may be fluctuating in the young child, and lacking in internal consistency within his adaptational pattern. His pattern of behavior may be altered by the social setting. Moreover, the child recovers from the effects of a stressful situation —up to a certain point—with some speed and reorganization. In spite of this recoverability, the child has a narrow range of defenses, because of the limitations of his life experiences. Even within this range, because of his helpless position and the fear of retaliation, he learns to retain some defenses and reject others in order to cope with life situations. Successful coping with frustration and the handling of a conflict which is not too great for the emotional level of the child can strengthen the ego and expand it. But these strivings toward development of self must go on in a family setting which provides some sense of security, satisfies some basic needs, and aids the child in socialization and development of identity. When the child's environment is one of physical or emotional deprivation or of hostile interaction, the process of growth is altered negatively.

The results are the varied personality and behavior disorders presented by the majority of children in long-term foster care. Clinically, some fall into the category of those institutionalized children suffering from severe emotional deprivation in infancy—the unstimulated and undeveloped child. More of them show varying patterns of behavior characteristic of many types of parental rejection; these range from the child with a habit disturbance in his tension-reducing efforts to the child with the conduct disorder, with both psychological and motor efforts at controlling others. In some, neurotic traits are prominent. In some, schizoid or compulsive features are marked.

Many of these children show disturbances at the time of placement. Others are not seen for intensive study until later. We then have to look at the results of early life disturbances, plus the results of the following factors specific to the placement situation: separation, placement and re-placement; impending discharge at an arbitrary date; and the inability or unwillingness of the parents to give up legal rights while maintaining inconsistent contact and responsibility, or none at all.

The burdens resulting from the trauma of separation, the uncertainty of placement, and the confusion of identity are inevitable. They must be offset to some degree by the skillful application of the knowledge of human behavior to the individual child throughout his stay in care.

## *Handling Feelings Aroused by Separation and the Act of Placement*

Separation from parents, beyond infancy, arouses characteristic feelings in the child which he handles in various ways, depending upon his chronological and emotional age, the

* Given at the CWLA Eastern Regional Conference, New York City, on April 20, 1961.

individual modes of adaptation which he has developed, and the reaction of significant persons with whom he relates. Certain of these feelings occur consistently: the child who is separated feels abandoned and rejected; bewildered by the experience, he feels helplessness added to his anxiety in the face of this act. He attempts to handle helplessness by denial or by blaming himself for being deserted. Thus, in assigning an active role to himself he feels less helpless, even though the role itself causes him further anxiety and guilt. At the same time, the anger that he feels towards his parents causes him to marshal further mechanisms of defense, since anger towards parents places him in danger of punishment even greater than abandonment—punishment of a quality which he can only vaguely perceive. Many of these feelings are beyond awareness; some can be expressed.

The act of placement increases further the feelings of helplessness. Since these feelings are not related directly to the parents, they may be more readily verbalized, and the court, agency or social worker may be blamed with a vehemence that indicates that its source is blame felt towards parents. Since the child fears that the new, unknown parents may also abandon him, he generally denies any kind of feeling about them or fantasy of them, or else overidealizes the situation to come.

An understanding of these frequently observed patterns of responses as well as of the individual child's previously used methods of coping will not only aid in the placement act, but will help in the choice of a foster home when used along with the caseworker's understanding of the potential foster parents and the other children in the home. In many instances, the child's patterns of relating have been developed in interaction with neurotic or psychotic persons in the natural family. The child in his new home continues to relate to these earlier patterns, continuing to use them or reacting in the opposite way. Difficulties arise when his actions are inappropriate, or too frightening, or mesh with the neurotic behavior of the foster family. Since many of these children come from cultural groups where feelings are revealed more in action than in words, they may use actions to express inner conflicts.

Stella was twelve when placed in a professional foster home after a year in a shelter. Placement came about when her mother's psychotic behavior came to the attention of the police. When placed, she triumphed over the situation by taking charge of the other children in the newly formed foster home. This continued until the foster mother realized her own part in allowing Stella to become her assistant. Then she clamped down and rejected the girl. Whenever this happened, Stella expressed the feeling that she would always be rejected. She had attempted to deny feelings of helplessness by control; denying her dependency needs, she gained temporary security.

A study of her family interaction revealed that Stella had been in charge of the family for two years during her mother's early psychosis. Thus for her very existence she had had to play the role of substitute parent. In the shelter she had assumed the same role. When the foster mother, who admired leadership, responded to her behavior as strength, the interaction continued. Moreover, Stella's guilt about having made her mother ill, which was itself related to her fear of helplessness, led her to provoke the situation she feared—rejection.

Casework begun with the foster parent, though late, was still able to help her to work on her role, her feelings of competition with a younger sister of her own, and her ability to allow dependency needs to be met. The child in turn, through psychotherapy, was able to admit dependency to some degree, to work through these feelings, and to develop strengths of a more appropriate nature. She was able to master new situations without such a toll being taken of her. During the years of a long placement, new stress situations reactivated old patterns of behavior (at times of symbolic or actual separation), but the frequency decreased.

### *Handling the Placement Situation*

For many children, long-term placement is never fully accepted as something which could happen to any child. Instead, many consider that *they* are bad, and therefore placed, and never move beyond this egocentric point. Such movement always requires assistance from foster parents, caseworkers or others. The child's *self-concept* is that of a bad, worthless and unloved person who has done something to cause his parents to abandon him, and he feels he can never find a person he can trust. Some fantasize that their parents

will rescue them and thus they need not trust those that they have now. The inconsistency of the natural parents furthers this fantasy. Others handle their low self-picture by trying to prove the opposite by compliance and denial of mixed feelings.

Some children show anxiety in their struggle to handle inner conflicts. Others are affectless, overcontrolled or seemingly unconcerned. The latter group may act out constantly and impulsively, and relate on a superficial, self-protective level, perhaps able to demand affection but unable to respond when it is given. For such children the group home with the foster parent who does not need gratification by social behavior or affection may be indicated. Should the child be able to reach the point where such a distant setting is no longer indicated, a change to a more appropriate setting, though arousing separation fears, would not be so disturbing an event as an unplanned, precipitous change when the foster parents in a regular home have come to the end of their rope.

The area of *identity* is another area of confusion, particularly when parents are inconsistently or malevolently in the background, keeping active for the child only anger, resentment and guilt. This child needs help with these feelings to move from a paralyzing relationship with the past to self-interest. The child who does have a positive family identification will need to give up the parent as do all children as their need for parents changes. This problem is made more difficult with the child whose years of placement have included several foster families, his own family, and parent substitutes, all of whom may share familial identification.

Certain children do seem to identify mainly with the foster family. Some of them are able to admit freely that they are not living with their real parents. For many others, however, the relationship is an "as if" one in which the child acts as if this were his real family, consciously or unconsciously denying reality.

In our society the very term "foster child" is derogatory. Thus, one child who is proud of the way her foster mother dresses her says, "Some kids come to school looking a mess; they look foster and they live with their parents. We look real nice. We don't look foster." Another rises above the situation and says, "Foster isn't so bad. You got two of everything, so it's better." Many others avoid the use of the word "foster" and change the relationship to that of "uncle" or "aunt." For a very few, the group identification may provide security. Here the worker must deal with the reality aspects of the child's place in the community, for in many communities with middle-class strivings there is rejection of the foster child. This may serve to reinforce the child's individual sense of unworthiness, and encourage, in the child so inclined, the antisocial behavior which the community fears must inevitably occur.

Neither the impersonal agency nor the changing social worker can provide a strong source of identification for most children in care, nor are most children even clear about the roles of agency or worker, or about the relationship of either to parents, foster parents and themselves.

Because of economic and cultural discrimination, a large number of children in long-term care are Negroes. The low socio-economic status of the Negro in the United States today is often used by the child to reinforce basic feelings of unworthiness. The reality aspects of racial identity, prejudice, and discrimination must be dealt with in working with the child before the deeper meaning of individual feelings of unworthiness can be worked with. The worker or therapist who, because of his own culturally and individually conditioned blind spots, fails to explore these areas will be denying as of valid concern to this child something which is a vital part of his identity. By shying away from this area, the worker will reinforce the idea that race is a bad or forbidden area, and thus another part of the child is bad. Similarly, the worker who, through guilt if white or overidentification if a Negro, stays only on the level of the reality factors, will not come to an understanding of the meaning of racial identity for the child, and its relationship to his own sense of identity.

In a like manner, sexual identity must be dealt with on several levels. For many of these

children the original home was one without a father or with changing and ineffectual father figures. In the foster home, the foster mother and her strengths are emphasized by the worker while the foster father is neglected. An understanding of the social and cultural factors of the groups in which these children are placed, with the dominant mother figure, must go along with understanding of the psychosexual development of the individual child.

The factor of *impermanence* is the last to be mentioned. No matter how long a child has been in care, the awareness, or preconscious recognition, of the fact that it may not last is there. Some fear that their actions may lead to another separation and are controlled and compliant. Others hope that they may provoke a return to their parents by antisocial acts. Seldom is the situation accepted as one without possibility of disturbance, whether threats are made by the foster parents or not. In many instances fear, coupled with an attempt to control, leads the child to precipitate what he is afraid of—another rejection.

### *Termination of Long-Term Placement*

Although the response to the prospect of termination varies, its meaning is the same: separation, with its attendant anxieties. Some react with efforts to return to parents, to master feelings of abandonment by undoing the act, even though they have intellectually understood that these parents have nothing to offer them. Others are glad to be rid of the authority of the agency and will not go along with planning. Many cannot see beyond the fact that they must leave at an arbitrary age, and they regress to previous levels of dependency. Some move from one dependent situation to another: a boy may enter the service or a girl may marry, each afraid to live on his own.

Some continue to live with the foster family because they feel a true tie to the family. Others stay because they are not prepared to leave. For those who are prepared educationally, vocationally, and emotionally for independent life, there has been a long period of planning. For most, casework services might well continue for a brief time beyond termination to aid in the transition.

### *Follow-up of Persons in Long-Term Foster Care*

In the private practice of psychoanalysis, I have had the opportunity of treating two women who were in care all of their childhood. Similar clinical observations to those presented above can be made; each woman had felt that she never belonged, that she might be moved at any time and must therefore control her feelings and behavior, and that she was a bad person who deserved the desertion she had received.

Erline, thirty years old, entered analysis because of difficulties with mothering. Analysis revealed that she was relating to two of her children as if they were different parts of her own foster-child identity: one, the unloved child whom she must either smother with guilt-ridden affection or threaten to send away; the other, the potentially lovable child who must earn love by compliance and denial of mixed feelings. Thus, the dynamics of her neurotic behavior were related to her having been in long-term foster care.

### *Psychological Indications for Modifications of Service to Children*

The goal of care is not only economic independence but a productive and integrated personality, within the limits possible for each individual. In spite of such goals, many children are lost in the records; many are shifted from home to home; many receive special services only in times of crisis; many are unprepared emotionally and vocationally at the time of discharge and are left to flounder. In order to minimize the effects of parent loss and separation and to strengthen the child's assets, there must be earlier and more consistent use of psychiatric and psychological services, integrated in a casework program.

*Before placement,* detailed knowledge of the child's mode of interaction can be used in the selection of a home. The child's need to repeat the past and the foster parents' manner of relating must also be kept in mind, and understood through team consultations and exploratory casework.

At the *time of placement,* such sharing of knowledge can help in the act of separation, so that the worker can help the child master the situation. For one child, ventilation of hurt and anger will be necessary; the aware-

ness that the worker is not anxious may support another child until he is ready for further exploration. For still another, preconscious fears may need expression through an interpretation by the worker.

A *comprehensive psychological and psychiatric study* is indicated for all children in care at the point in their placement, between the fourth and the sixth month, when the settling-in period is over and patterns of relating, needs and problems are apparent. Such a study, related to the caseworker's observations plus the observations of the foster parents, must be followed by an interdisciplinary planning conference and the making of a plan. A family conference with the child, foster parents, caseworker, psychiatrist and psychologist follows. Periodic review and change of plans is necessary in accordance with the child's changing needs and drive toward growth, as well as the foster parents' ease of relating to, and awareness of, changing needs of children of various ages.

*Periodic review* is particularly indicated at those times which place stress on all children, and particularly children sensitized to separation, new tasks, dependency and independence, and identity problems. Thus, periodic review is indicated at the beginning of school, during latency, and during adolescence, so that planning can be carried through in time to help the child handle these new life periods.

*Psychotherapy* is certainly not indicated for all children in care. A certain number, unable to form object relationships because of the quality of early deprivation, will need a period of ego strengthening from the therapeutic environment before they can possibly be helped by therapy. For some, a casework relationship may act as a corrective experience. For others, with severe pathology but indications of basic strength, psychotherapy is indicated: it may be of the insight type, or it may serve as an aid in growth at a difficult period. It must be supplemented by casework, ancillary services, and work with foster parents and other significant persons in the child's life.

New methods of therapy are imperative—group therapy, for example; structured group counseling; and group observation of the young child as a prelude to individual study where indicated. Group therapy, or individual therapy for certain persons, might well continue after discharge.

*Consistent work with foster parents* before and during placement is needed, on an individual casework basis as well as in group meetings. Special effort should be made to clarify the role of the foster parents and to reach foster fathers.

*Modified types of foster home setting,* such as the small residence and the group home, must be planned, not only because they can serve the needs of more children but because some of these settings are indicated for many children who cannot endure close relationships or respond to the emotional demands of the regular foster parents.

### *Conclusion*

The early life experiences of the child in long-term placement, as well as the placement situation itself, demand of the child a certain adaptation. Observation of the child's pattern of adaptation, and that of the foster family, can provide indications of the possible outcome of placement. Such observations can be utilized by the agency interdisciplinary team to aid in choosing a home, to help the child's growth and development during placement, and to aid in casework with the foster parents, so that frequent and damaging re-placements of the child may be avoided.

To provide preventive and therapeutic services, a comprehensive social, psychiatric and psychological study should be done at an optimal point after intake, and a plan for implementation of resulting recommendations should follow. Periodic review, evaluation, and modification of this plan is essential, particularly at the times in the growth process and the placement history when stress is anticipated.

New methods of observation, study and therapy must be utilized to serve the child in long-term placement; new types of placement must be evolved. In observation, planning and service the child must be recognized as an individual who has individual strengths, needs, and strivings towards health, and is affected by the social, economic and cultural factors in his life.

# NEWS FROM THE FIELD

## *An International Appraisal of the 1960 White House Conference on Children and Youth* *

I was asked to give my impressions from an international viewpoint of the Golden Anniversary White House Conference for the 500 foreign guests on the last day. What I should have said is this. I personally was impressed by the vast amount of material available, and also by the way criticism was honestly and unreservedly given, but frankly—speaking from an international standpoint—this Conference brought nothing remarkable in regard to ideas, description of situations and proposals. Foreigners working in the field of child welfare and who keep up to date with new developments would have learned nothing new at the Conference. For, in fact, all the Western countries share the same kind of problems, the same lacks and the same mistakes—maybe in a different relation and to a different extent.

You can say that the strength of this mass conference lies in its preparation—in this case the influence, for example, of the State Committees, local groups and voluntary agencies, which approximately three years prior to the Conference discussed all kinds of aspects of child welfare.

Today we are living in a changing world—changing more quickly than ever before, and from this point of view we are much more critical and we find it a basic weakness in a democratic community that increasing wealth, as is the case in the United States, has not been matched by a parallel increase in expenditure to improve social security, housing programmes, educational, social and health services; in other words, to broaden and deepen preventive work and, in regard to juvenile delinquency, to make good the many shortcomings in this field.

Looking at all these White House Conferences, we wonder why no follow-up action is taken, and how people can be quite happy every time with so many recommendations of which a great deal are not implemented.

It was an excellent idea, for example, to let the youngsters take part in the discussion, to let them assume responsibility, but what is worse for young people than to find out afterwards that the many recommendations which they shared in drawing up have not been carried out by the adults?

For the guests from developing areas, such a Conference must be quite bewildering. The amount of criticism that they hear must be very difficult for them to digest as being the strength of democracies on the road to improvement. They must wonder why the community, the State and the Federal Government let things go so far, why a country which has the money and means to improve the situation—which their countries have not, much as they would like to—does not do so. Involuntarily they must think about the publications on the care of youth in the communist countries, which only relate the good things without giving any criticism. From their point of view, I agree with Potter, who declared that it was incredible that a Conference booklet on children in a changing world did not include a whisper of the world beyond the United States. Even though this Conference was a national one, I think Potter is quite right when he asks whether Americans are implying that all they need do is to concern themselves with their own welfare, which would then automatically become the welfare of the world. As he concluded, with so many people in other countries needing the skills of the West, a golden opportunity exists to appeal to our children and youth to give their services for the uplifting of other people.

. . . . .

To finish, the United States have top national child welfare agencies, such as the Child Welfare League of America, the Children's Bureau of the Ministry [Department] of Health, Education and Welfare, and many others. There is no country in the world which has produced so much literature about social work and child welfare work techniques as America. There is no other country in which voluntary agencies participate to such an extent and which carries out such vast activity in the field of fund-raising.

The United States have more skyscrapers, more movies, more cars, more TV's, more radios, more refrigerators, more and bigger newspapers and so on than any country in the

* Reprinted from the *News Letter of the International Union for Child Welfare*, No. 84, July/August 1960.

world. I wonder, however, if they have not the biggest youth problem too? It is obvious to me that they do not have the biggest and most successful legislation and most efficient action for coping with youth problems today and in the future.

America is worried about her youth, and the Golden Anniversary White House Conference has proved that she has good reason to worry. My conclusion is that in the basement of the house of Uncle Sam, for too long the dirty washing has been piling up, but in my opinion, no country in the world is better equipped than the U.S.A. in qualities, strength and means to do an excellent job of cleaning. It is, however, high time to do this, and very thoroughly too. (See recommendation in composite report of forum findings, 1960, White House Conference on Children and Youth, Government Printing Office, Washington[,] D. C.) But one cannot clean only with recommendations, for these are like wonderful coloured balloons in the sunny heavens of wishful thinking, but on the hard road to the future we are better helped by efficient signposts pointing to compulsory action, and by firm "No Parking" signs. The recommendations of the White House Conference will serve no real purpose unless they represent the compelling voice of the people for Congress and the Federal and State authorities to realize them.

As I left the Conference, a very old Chinese proverb came into my mind: "While the weather is still fine, clean the drainpipe." I think too that if a country does not invest enough money to serve primarily its youth, it is really wasting its capital and jeopardizing its future.

DAN Q. R. MULOCK HOUWER

*Secretary General*
*International Union for*
*Child Welfare*
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## League Headquarters at National Conference

During the 1962 National Conference on Social Welfare, to be held May 27 through June 1 in New York City, all meetings of the Child Welfare League of America, including the dinner, will be held at the Hotel Sheraton-Atlantic.

# READERS' FORUM

### *Mrs. Charnley Responds to Criticism of Her Reporting and Motives*

*To the Editor:*

I echo Dr. King's request that someone write a book such as the one she has in mind. It would seem to me it should be someone who had spent at least four years working in another culture. It should be someone with a good bit of strength for if she does not approve political, economic, cultural or social structures that lead to unhappy consequences such as thousands of children growing up in institutional care, and if she says so, she may receive some pretty rugged criticism.

I, of course, did not try to write such a book. I also hope that if another social worker has had a limited experience such as mine in Australia or Ghana or Mexico she will make the effort to write and tell how it looked to her, what she saw and heard and thought about the experience. I remember as a student asking, "How is social work practised in other countries of the world? Do *they* have agencies, records, supervisors? Do they use casework principles similar to ours, or do they have quite another set?" I drew few answers from my instructors. If someone should write such a book, and if she reported only what happened to her, I would not criticize her for what her book would not pretend to be. I would not say that because she is American she should not report negative experiences. And if she reported accurately what she saw and heard, it would not occur to me to call her unethical. Europeans criticize our systems quite frequently and though we may smart a bit, we would do well to heed and study what "the foreigners" find to criticize in our country.

Dr. King writes that Herbert Kubly announced that he was in Italy to write a book about Italy. He had an advantage over me; I did not know that I was. I kept "the diary" at first as a case history of a process entirely for my own use. Social work friends with whom I later shared it wrote urging me to write it into a book. . . . After I had been home awhile, I showed the crude diary to my publisher, who thought that there was material here that might make a book that should be added to the literature of social work.

As I wrote in the introduction, I spent some

time trying to think how I could tell this story without embarrassment to those Italians with whom I had worked, those new friends with whom I shared a mutual liking and respect. I faced a problem similar to that that social workers face all the time in disguising case histories. I used an unusually elaborate and difficult technique in disguising. It was not the relatively simple process of changing names and places that is common. Instead, I made a mosaic of people, places, and quotations. So that if anyone recognizes, or thinks he recognizes, himself, he can say, "But I didn't say that, or do that." My introduction will support him.

I had some fleeting thoughts about asking permission of people with whom I had worked. I thought of a letter that would go like this: "Dear Signorina X. I am thinking of using parts of a conversation we had together almost a year ago in a book that I am writing. I had thought of disguising you as a man, placing you in another city, and mixing up in your speech four different conversations I had with you and three other Italians. Will you give your permission?" It seemed ridiculous and so I let it pass. I did write to two Italians with whom I had been especially close and they expressed real pleasure at the idea.

I have learned from my first book that the client disguised in writing, if read by clients, becomes a kind of screen onto which identifications of self and others can be projected. Two adolescents with whom I began work after *The Art of Child Placement* was written "found" themselves, their parents or their foster parents in my book. It appears now that social workers and clients may have this in common, for there are those who "recognize" themselves and others in the book when as *individuals* they are not really there.

I am sorry that Mr. Granger's letter was written before he read the book and was based only on the excerpt in CHILD WELFARE. Perhaps, having read the whole book, he will think that it was written in the manner he suggests, perhaps not. I am, however, troubled by advice that suggests that any reporter should assume a certain style, manner, or attitude that might not reflect his true feelings. This, to me, seems dishonest.

On my desk, I have two piles of letters and reviews of my book. One is fat and tall; the other is small. I have divided them into those who liked the book and looked on it as "a contribution" and those who disliked it for reasons such as Dr. King suggests. I am tempted to quote from the much larger pile in my own defense. There are the reviews from two Italian newspapers that expressed the idea that Italians should be more aware of what they are doing in "denying the importance of the Italian Mama" in bringing up so many children in institutional care. Neither journalist felt that I had written in a humiliating fashion. They used warm Italian adjectives as they recommended the book to Italian readers. I have a letter from an American woman who has given more than twenty-five years of her life to working at the executive level in child welfare in Italy who begins her letter, "Thank you! Thank you! Thank you for having written that wonderful book." To sort out, present and defend (when defense is needed) all the good and bad things that have been said would be an imposition on readers and editors of CHILD WELFARE.

But I should like to raise one more protest. Dr. King writes that I wrote the book "for personal profit and public entertainment rather than professional advancement." I would like now to speak for myself as to my own motives. My agency gave me leave to spend one day out of five on this writing project. For this, I willingly gave up one-fifth of my salary. I find it impossible to estimate the hundreds—or was it thousands?—of hours of hard work—days and nights—that went into the project. My publisher, being a university publisher, believes that there are books that might have a small audience that should be published in the interest of knowledge even though the books may lose money. We both anticipated rather a small audience. And so, because of the deficit the Press expects to incur, I added as my contribution to social work literature my willingness to do the job without royalties. The many expenses that are part of writing a book, I also paid for myself. So my personal profit seems to me a reverse sort of thing. I visualized this as a gift to my profession and I thought secretly that it was quite a handsome one. Dr. King writes that I did not write for professional advancement. I assume she means "advancement of the profession of social work."

I believe that clients, writers, and all people have the right to describe their own motives. I wrote with the hope that I would make a small filling in the enormous gap that exists in American social work literature about how social work is practised in other settings. I wrote hoping that someone—American, or Italian—might read the book and decide to do whatever he could to save ten or one hundred normal children from institutional living. I had in mind not only Italian children but also American children. I wrote also because I felt that in this opportunity to work in Italy I had been given a wonderful gift—the chance to come to know and respect another group of social workers. It seemed to me that the story of how this experience unfolded was worth sharing with the members of my profession in America. Some of these members would be going abroad on similar assignments to Italy and other countries. Had I been able to find such a book before I went, even though it described a professional adventure in another country, this would have been most helpful.

So here it is—a gift I chose to make to my profession. If to some it seems I offer an unethical gift, I can only express amazement and sorrow and my own deep belief that I did not.

JEAN CHARNLEY, M.S.W.
*Minneapolis, Minn.*

### *A Thirteen-Point Program To Solve Social Welfare's Manpower Needs*

*To the Editor:*

In the February issue of CHILD WELFARE, Dr. Ernest Witte summarized the manpower problem in social welfare and outlined the steps which have been taken to correct the situation. It seems to me that he has settled for too little too late. I would therefore like to suggest the following thirteen-point program, not only as a more comprehensive plan than Dr. Witte's, but one which must be adopted if needed staff is to be obtained. It is hereby proposed:

1. That a national social welfare manpower commission be established, representing all fields of social work emphasis, levels of private and public agencies, private citizens, financial control organizations, social welfare educators, professional organizations, and geographical areas.[1]
   a. That additional grants of funds be obtained to support such a commission and its staff.
   b. That the commission formulate a realistic broad outline of proposed public policy in relation to welfare staffing for both current and long-range needs in public and private agencies.
   c. That the commission identify the areas which require specific research data and conduct such studies as are applicable.
   d. That the commission assist in developing state and local manpower organizations and programs to accomplish its purpose.
2. That each state establish a social welfare manpower commission with representatives from all public and private agencies and groups with a stake in recruitment to serve in liaison with the national commission.
3. That the national and state commissions draw up plans for recruitment, training, and utilization of staff, and establish objectives and operational methods for use by agencies and individuals.
4. That the state social welfare manpower commissions encourage the organization of community- or area-wide social welfare manpower commissions to operate recruitment programs at the local level and to assist in financing such activities through private or public funds.
5. That consideration be given to identifying the number and quality of social workers needed now and for the next ten years.
6. That every effort be made to create undergraduate majors in private and public colleges and universities, under the direction of qualified social work educators.
7. That state and local public and private agency appropriations be obtained for

[1] The Council on Social Work Education committees may be meeting the objectives of this point. It is assumed that their membership representation and activities might well be expanded and intensified.

on-the-job training and for scholarships, and that Federal policies be changed to require that states match available Federal training funds on a percentage basis in relation to Federal administrative funds made available to the state.

8. That the need for additional public graduate training facilities be determined and funds for their development be obtained through Federal and state legislation.
9. That operating agency standards for field work practice and facilities be established and that Federal, state, and local agencies assume fiscal and administrative support for the development of such facilities.
10. That the existing social welfare personnel structure be reviewed in terms of long-range and immediate goals in order to evaluate and restructure job classification systems in relation to education and experience, personnel supply and requirements for various classes, methods of recruitment, examination, requirements for advancement, competitive salaries, and other benefits. The ability of workers to transfer between levels of jobs, between agencies, and between geographical areas, without loss of professional status or economic advantage, should also be considered.
11. That plans be developed for more effective use of staff in relation to their education and experience, through caseload classification and caseload standards.
12. That public understanding and citizen and taxpayer support for a comprehensive plan for staff recruitment, training, and utilization be obtained through a program publicizing welfare staffing needs.
13. That welfare administration and fiscal control groups be influenced to pursue welfare personnel practices which will result in obtaining and retaining the maximum volume of quality staff.

Even though social work leaders have been attempting to solve the manpower problem since 1930, a new and drastically different approach must be found if the trend is to be reversed. I feel that unless many others besides social workers and schools of social work are deeply involved, as the thirteen-point program envisages, this problem will remain unsolved.

ARTHUR W. POTTS
*Chief, Bureau of Aid to Needy Children*
*Department of Social Welfare*
*Sacramento, California*

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## Fletcher

*(continued from p. 14)*

through which to sell the public on the agency need. Unfortunately, this is not enough, and the day has come when professional assistance is needed to produce the kind of public relations required today. You may not have to pay for it, perhaps, but skill and training are required to achieve a desirable image before the public, which has been educated with the techniques of the "hidden persuaders" of advertising.

### *Political Understanding Essential*

A new qualification must be included in board membership if the children's agency is to be successful in dealing with the public agency. The board must have among its members those with political "know-how." It is not necessary to point out that political "know-how" includes not only the knowledge of the elements involved but the use of careful timing, patience, and tenacity. There must be a clear-cut understanding of the law and of what the public agency can do and what it cannot do.

Public servants know the language of votes. They and/or their superiors and their funds are all dependent upon the voters. The modern agency must have pressure groups to represent its needs and provide support. This means, among other things, a strong membership. This is a job for board members today.

Most basic of all is the dedicated, carefully chosen group of citizens who have been selected because of the contribution they can make to help solve one of the particular problems of the children of this community. The role of trusteeship never has been so vital as it is today. Such is the board member's job, as I see it.

# CLASSIFIED PERSONNEL OPENINGS

**Classified personnel advertisements are inserted at the rate of 15 cents per word; boxed ads $7.50 per inch; minimum insertion $3.00. Deadline for acceptance or cancellation of ads is SIXTH of month preceding month of publication. Ads listing box numbers or otherwise not identifying the agency are accepted only when accompanied by statement that person currently holding the job knows ad is being placed.**

CHILD WELFARE WORKERS & SUPERVISORS—Arizona needs you if you have 1 year of approved graduate training. Most openings are in rural areas. Good recreational facilities. Good fringe benefits. State retirement plus OASI. Write: Arizona Merit System, State Capitol Building, Phoenix, Ariz.

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ADOPTION WORKER. Immediate opening for MSW with or without adoption experience. 35 hr. wk. Fee and auxiliaries financed. Salary commensurate with experience—minimum $5700. Maximum open. Beautiful San Joaquin Valley area. Contact William J. Freni, Director of Casework, Infant of Prague Adoption Service, 640 E. Franklin Ave., Fresno, Calif.

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CASEWORKERS—Several immediate openings for mature, flexible, competent persons. Challenging work situation. Required: MSW with or without experience in child or family welfare agency. Salary related to applicant's qualifications. Fringe benefits. Write: The Adoption Institute, H. Gordon MacKay, Executive Director, 1026 S. Spaulding Ave., Los Angeles 19, Calif.

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LOS ANGELES—Openings for two caseworkers with graduate training in expanding family and child welfare agency—multiple services including marital counseling, unmarried parents, financial assistance, child placement in foster home care and group care, psychiatric consultation. Highly qualified supervision. Standard personnel practices. Opportunities for advancement. Salary, $5712–$7548 depending on training and experience. Write: Rev. William J. Barry, Assistant Director, Catholic Welfare Bureau, 1400 W. 9th St., Los Angeles 15, Calif.

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CASEWORKER II or III (male preferred). In parent-child guidance service to families with troubled boys, aged 6 to 18, primarily youthful offenders. Psychiatric and psychological consultation available. MSW required. II—$5712–$7140; III—$6384–$7980, five step plan, salary commensurate with experience. Social Security, retirement, health insurance. Milton L. Goldberg, Executive Director, Jewish Big Brothers Association, 590 N. Vermont Ave., Room 366, Los Angeles 4, Calif.

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CASEWORKERS (2) for psychiatrically oriented Jewish child placement service. Responsible for casework services to children in cottage placement and limited foster home case load. Excellent psychiatric and psychological staff. MSW required. Retirement plan, Social Security, excellent personnel practices, car allowance, participation in health plan. Good supervision. Salary range: Caseworker II, $476–$595; Caseworker III, $532–$665. Karl Freeman Glou, Vista Del Mar Child-Care Service, 3200 Motor Ave., Los Angeles 34, Calif.

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CASEWORK SUPERVISOR—Nonsectarian, child placement agency. Services include parent counseling, casework with deeply troubled children, foster family care, family day care, intercountry adoption. Adoption program for children within agency now being developed. Regular psychiatric consultation. Retirement plan, Social Security, good personnel practices, health insurance, member CWLA. Salary: $6384–$8436 in 6 steps. Highest entrance salary: $7548. Mrs. Ernestine Wood, Children's Bureau of Los Angeles, 2824 Hyans St., Los Angeles 26, Calif.

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DIRECTOR—Small, nonsectarian, forward-looking, residential, group-care agency for boys and girls, 6 to 12 years of age, with minor emotional disturbances and behavior problems. Reorganizing with purpose and objective of effecting a treatment-oriented program in line with modern concepts of child care. Actively participating and supportive board. Established facilities with real potential. Good location. Part-time pediatrician and psychiatrists' services. Requirements: (a) MSW and at least 5 years' experience in child welfare, including 2 years of executive experience; or (b) a combination of education and experience comparable to (a); demonstrated leadership and ability in organizing and directing program operations, institution management, directing of board and committee activities, and maintaining public relations. Starting salary: $7000–$9000, depending on experience. Insurance and fringe benefits. Immediate opening. Call or write for application to Pasadena Children's Training Society, Personnel Committee Chairman, 1125 East Del Mar Blvd., Pasadena, Calif.

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CASEWORKER—For small, forward-looking, residential, group-care agency for boys and girls, 6 to 12 years of age, with minor emotional disturbances and behavior problems. Psychiatric consultation and psychotherapy available. MSW with psychiatric orientation required. Some group-work training desirable. At least 1 year's experience in child welfare. Salary: $5400–$6756. Fringe benefits. Immediate opening. Call or write for application to Pasadena Children's Training Society, Personnel Committee Chairman, 1125 East Del Mar Blvd., Pasadena, Calif.

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IMMEDIATE OPENINGS for child welfare services worker in adoptive and protective services programs. Salary range: $5880–$7152. Two years' graduate study required with substitution of experience for second year acceptable. Citizenship required. Child Welfare Division, Sacramento County Department of Social Welfare, 921 10th St., Sacramento 14, Calif.

CHILD WELFARE